

UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF WISCONSIN

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JAMES GRANDBERRY,

Plaintiff,

- vs -

Case No. 19-CV-689

SL HARBOUR VILLAGE, LLC,

Defendant.  
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Examination of DEBRA BARTH, taken at the instance of the Plaintiff, under and pursuant to the Federal Rules of Civil Procedure, before SAMANTHA J. SHALLUE, a Registered Professional Reporter and Notary Public in and for the State of Wisconsin, with all participants appearing via Zoom videoconference, on December 22, 2020, commencing at 1:03 p.m. and concluding at 3:28 p.m.



## A P P E A R A N C E S

CADE LAW GROUP, LLC, by  
MR. NATHANIEL CADE, JR.,  
P.O. Box 170887,  
Milwaukee, Wisconsin 53217,  
appeared via Zoom on behalf of the Plaintiff.

HINSHAW & CULBERTSON, LLP, by  
MR. COREY J. SWINICK,  
100 East Wisconsin Avenue, Suite 2600,  
Milwaukee, Wisconsin 53202,  
appeared via Zoom on behalf of the Defendant.

\* \* \* \* \*

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\* \* \* \* \*

## 1 TRANSCRIPT OF PROCEEDINGS

2 DEBRA BARTH, called as a witness  
3 herein, having been first duly sworn on oath,  
4 was examined and testified as follows:

## 5 EXAMINATION

6 BY MR. CADE:

01:03:30 7 Q Ms. Barth, good afternoon. My name is Nate  
01:03:33 8 Cade, and I'm the attorney for James  
01:03:37 9 Grandberry. We are obviously doing this via  
01:03:39 10 Zoom which makes it a little more difficult.  
01:03:45 11 I'm sure you've had conversations with  
01:03:48 12 Mr. Swinick, but there's only a few rules for a  
01:03:51 13 deposition which are even more important now  
01:03:53 14 that we are doing it via video as opposed to  
01:03:57 15 live.

01:03:58 16 So the first thing is that you and I  
01:04:02 17 cannot talk over each other, and by that I mean  
01:04:07 18 Sam, our reporter here, is an excellent  
01:04:10 19 reporter -- I've used her in the past -- but  
01:04:14 20 reporters make mistakes, especially over video,  
01:04:17 21 and if I start asking questions and you jump in  
01:04:21 22 with the answer, what could end up happening is  
01:04:24 23 the transcript gets discombobulated and it has  
01:04:30 24 you asking the question and me giving the  
01:04:32 25 answer. So it's important that while I am



01:11:58 1 A I know that she was a memory care resident, and  
01:12:02 2 I was familiar with her at the time knowing who  
01:12:04 3 she was.

01:12:05 4 Q Okay. And if Mr. Grandberry has testified that  
01:12:10 5 [REDACTED] used a wheelchair and needed  
01:12:13 6 assistance to get on and off the toilet, would  
01:12:16 7 you have any reason to dispute that?

01:12:21 8 A I would not have a reason to dispute that, no.

01:12:23 9 Q Okay. And the location of where she was found,  
01:12:27 10 do you know which particular bathroom she was  
01:12:30 11 located or found in?

01:12:31 12 A Yes.

01:12:31 13 Q Which bathroom?

01:12:32 14 A She was found in the bathroom that was right  
01:12:34 15 off of the dining room. So it would be to  
01:12:40 16 the -- if you are facing the kitchenette area,  
01:12:45 17 the stove and refrigerator, it is the bathroom  
01:12:49 18 to the right of the refrigerator.

01:12:51 19 Q Okay. Is that a single-use bathroom?

01:12:54 20 A Correct.

01:12:54 21 Q Single person?

01:12:55 22 A Yes.

01:12:56 23 Q Okay. And you said it was a locked door?

01:12:59 24 A The door could be locked.

01:13:00 25 Q Right, but at the time it was locked?

01:14:21 1 locked it, correct?

01:14:22 2 A Correct.

01:14:22 3 Q And if it's locked from -- at least on the  
01:14:28 4 outside, if someone comes along and twists the  
01:14:32 5 handle, I'm assuming, because it's locked, it  
01:14:34 6 can't be opened, right?

01:14:36 7 A Correct.

01:14:36 8 Q And that's the point of having the lock,  
01:14:39 9 someone just can't walk in on you just because  
01:14:43 10 they twist the door handle, right?

01:14:45 11 A I would assume you're right.

01:14:46 12 Q Okay. So the only way to open it would be some  
01:14:50 13 sort of master key to get it open, fair?

01:14:52 14 A Yes.

01:14:52 15 Q Okay. And do you know how they were able to  
01:14:56 16 determine that [REDACTED] was in the bathroom  
01:15:00 17 at the time she was located?

01:15:02 18 A Yes. A caregiver came downstairs from a unit  
01:15:08 19 upstairs, and when she was going through, the  
01:15:13 20 co-worker to James said, "I can't find this  
01:15:16 21 resident," and they started opening all of the  
01:15:20 22 doors and looking and searching for the  
01:15:24 23 resident. They went to the bathroom door, they  
01:15:28 24 opened the bathroom door, and the resident was  
01:15:32 25 laying on the floor.

01:16:49 1 talking about just in terms of handling her.

01:16:54 2 Is that a possibility at Harbour Village that

01:16:58 3 if I have an elderly mother or grandmother and

01:17:01 4 I'm concerned about men touching her, that I

01:17:04 5 can say, "I only want female attendants

01:17:07 6 handling my mother or grandmother"?

01:17:09 7 A There would need to be a reason, and it would

01:17:12 8 need to be care planned.

01:17:12 9 Q Okay. If you -- well, let me back up. The

01:17:25 10 other individual who was on shift with

01:17:31 11 Mr. Grandberry at the time was Jill Bayer,

01:17:35 12 B-A-Y-E-R?

01:17:35 13 A Yes.

01:17:36 14 Q And what's the name of the individual who

01:17:39 15 placed [REDACTED] in the bathroom?

01:17:42 16 A Kim Mims.

01:17:47 17 Q Spell that last name.

01:17:49 18 A M-I-M-S.

01:17:50 19 Q Was -- was Mr. Grandberry fired the same day

01:17:56 20 the resident went missing and then was found?

01:18:00 21 A Was he fired?

01:18:02 22 Q Yes. Was he terminated, his employment?

01:18:05 23 A No, not on the same day.

01:18:07 24 Q What day was he terminated? The next day?

01:18:10 25 A On the 6th. He was suspended -- he was told he

01:18:13 1 was suspended on the 4th.

01:18:15 2 Q So the resident went missing on the 4th?

01:18:20 3 A Correct.

01:18:20 4 Q And then two days later he was terminated?

01:18:25 5 A Correct.

01:18:26 6 Q Ms. Bayer was suspended on the 4th?

01:18:32 7 A Correct.

01:18:32 8 Q And was she terminated on the 6th?

01:18:37 9 A Correct.

01:18:37 10 Q What about Ms. Mims, was she suspended on the

01:18:42 11 4th?

01:18:42 12 A She was -- had already left on that day, so she

01:18:49 13 was not suspended on that day. I did do a -- I

01:18:54 14 did speak with her as part of the

01:18:56 15 investigation.

01:18:57 16 Q Was she suspended for her involvement in this

01:19:01 17 matter?

01:19:04 18 A I am not sure if she was suspended.

01:19:09 19 Q Well, I'm a little perplexed, ma'am, Ms. Barth,

01:19:15 20 because you have familiarity with

01:19:17 21 Mr. Grandberry; you have familiarity with what

01:19:19 22 occurred with regards to Ms. Bayer. Why is it

01:19:23 23 that you do not have familiarity with what

01:19:25 24 occurred with Ms. Mims? I mean, you would

01:19:28 25 agree with me she's directly involved, correct?

01:19:31 1 A Yes.

01:19:31 2 Q You would agree with me that placing a resident  
01:19:36 3 on the toilet who is wheelchair-bound and  
01:19:39 4 unable to assist or unassist themselves is not  
01:19:43 5 within the policy of Harbour Village, correct?

01:19:48 6 A It would not be -- yes, it would not be what we  
01:19:52 7 would want to do, to leave a resident  
01:19:54 8 unattended, correct.

01:19:57 9 Q Okay. Did [REDACTED] have the ability to  
01:20:00 10 clean up after herself, wipe herself, or did  
01:20:03 11 she need assistance with that?

01:20:05 12 A She needed assistance.

01:20:06 13 Q So I'm troubled -- do you know how long [REDACTED]  
01:20:12 14 [REDACTED] had been on the toilet?

01:20:16 15 A It was reported by Ms. Mims that she had put  
01:20:19 16 her on the toilet at approximately 2:50 and --  
01:20:26 17 or 2:55 and had reported off to the incoming  
01:20:32 18 shift at 3:00 p.m. that she was on the toilet  
01:20:35 19 and they should take her off of the toilet, and  
01:20:39 20 she left her shift at approximately 3:00 p.m.

01:20:41 21 Q Okay. Did she say who she spoke with that day  
01:20:45 22 about placing [REDACTED] on the toilet?

01:20:47 23 A She said that she told Jill that she had put  
01:20:54 24 the resident on and that James was in the area  
01:20:57 25 and that Jill had nodded which she took to be

01:21:03 1 an affirmation that Jill was going into the  
01:21:07 2 bathroom to attend to the resident.

01:21:09 3 Q Okay. So let's break that down. Ms. Mims  
01:21:13 4 states that -- was Ms. Mims -- I asked you  
01:21:18 5 about suspension, and I apologize. Was she  
01:21:19 6 terminated for her involvement in this  
01:21:22 7 incident?

01:21:22 8 A She was not.

01:21:24 9 Q Okay. So Ms. Mims tells Ms. Bayer, "Hey,  
01:21:32 10 [REDACTED] on the toilet," and she gets a nod  
01:21:37 11 from Jill which Ms. Mims took as an affirmation  
01:21:42 12 that Ms. Bayer understood that [REDACTED] was  
01:21:47 13 left alone?

01:21:49 14 A Correct. She also stated that James would have  
01:21:53 15 heard her because he was in that area with them  
01:21:56 16 at the same time.

01:21:58 17 Q Did you -- did you ever ask James whether he  
01:22:02 18 heard Ms. Mims state that [REDACTED] was on  
01:22:06 19 the toilet?

01:22:13 20 A I would have to look at a statement that I had  
01:22:18 21 written based on my investigation with James.

01:22:20 22 Q Okay. What statement are you looking at,  
01:22:23 23 ma'am?

01:22:23 24 A I'm not looking at a statement right now. I  
01:22:26 25 know there are statements that are exhibits.

01:22:28 1 Q Okay. Well, I'm going to show you Exhibit 13,  
01:22:34 2 if you need to read a statement.

01:22:36 3 A Okay.

01:22:37 4 Q Can you see the screen, ma'am?

01:22:49 5 A I can, yes.

01:22:51 6 Q Okay. Now, before we go into this statement,  
01:22:57 7 this is -- you typed this statement up,  
01:22:59 8 correct?

01:22:59 9 A Correct.

01:23:00 10 Q This is not a statement that Mr. Grandberry  
01:23:04 11 either handwrote out and you typed or that you  
01:23:08 12 wrote up and that he initialled or indicated  
01:23:11 13 that these are his words, fair?

01:23:14 14 A Correct.

01:23:14 15 Q Okay. Go ahead and take a moment and read  
01:23:18 16 Exhibit 13.

01:23:42 17 A Okay. I've read it.

01:23:43 18 Q Okay. I've read it as well, and nowhere on  
01:23:49 19 there does it indicate that Mr. Grandberry  
01:23:55 20 acknowledged that he overheard Ms. Mims stating  
01:23:59 21 that [REDACTED] was on the toilet, fair?

01:24:04 22 A Correct.

01:24:04 23 Q And let me understand if -- did you take the  
01:24:11 24 statement from Mr. Grandberry on the 4th, the  
01:24:16 25 day he was suspended?

01:24:17 1 A Correct. That evening before he left at --  
01:24:21 2 before he was suspended at the end of his  
01:24:24 3 shift, I was on campus, and I met with him  
01:24:27 4 personally and took his statement.

01:24:28 5 Q So when you took the statement, when you -- I'm  
01:24:31 6 assuming you were sitting at a computer?

01:24:33 7 A I was not sitting at a computer.

01:24:35 8 Q Okay.

01:24:35 9 A I wrote it, and then I -- I wrote it down, and  
01:24:38 10 I typed it the next morning as I had written it  
01:24:43 11 down.

01:24:43 12 Q Where are the notes that you used to type this  
01:24:47 13 with?

01:24:49 14 A I don't know. I don't have them, I don't  
01:24:51 15 believe, any longer.

01:24:52 16 Q So at one point you have handwritten notes, and  
01:24:58 17 then after handwriting those notes, you --  
01:25:02 18 they're gone; they're disposed of?

01:25:06 19 A I don't have them in front of me now. I don't  
01:25:08 20 have them.

01:25:09 21 Q Well, I made a discovery request for all of the  
01:25:12 22 documents with regards to the file. So other  
01:25:14 23 than being in Mr. Grandberry's file, if the  
01:25:18 24 notes still existed, where would they be in  
01:25:20 25 existence at?



01:34:02 1 A I would not.

01:34:04 2 Q So if you were doing an investigation, wouldn't  
01:34:08 3 you want to know whether in fact Ms. Mims was  
01:34:14 4 being truthful with you when she gave you an  
01:34:16 5 explanation of what occurred?

01:34:18 6 A Yes.

01:34:19 7 Q Okay. But you never bothered to follow up to  
01:34:23 8 verify whether in fact she was truthful; you  
01:34:25 9 assumed she was truthful?

01:34:27 10 MR. SWINICK: Object to form;  
01:34:29 11 misstates the witness's testimony.

01:34:31 12 MR. CADE: You may answer, ma'am.

01:34:34 13 THE WITNESS: Do you want to ask the  
01:34:36 14 question again, please?

01:34:36 15 MR. CADE: Sure.

01:34:37 16 THE WITNESS: Thank you.

01:34:37 17 BY MR. CADE:

01:34:37 18 Q You assumed Ms. Mims was being truthful, fair?

01:34:43 19 A Yes.

01:34:43 20 Q Okay. Now, what time was [REDACTED] located?  
01:34:54 21 What time was she found?

01:34:57 22 A Approximately 7:50 p.m.

01:35:01 23 Q Okay. Other than informing Ms. Bayer  
01:35:11 24 purportedly where [REDACTED] was located, is  
01:35:15 25 there any other -- let me rephrase.

01:36:34 1 Mr. Grandberry, she should have specifically  
01:36:37 2 told them and they should have waited outside  
01:36:39 3 the door for [REDACTED] to finish, fair?

01:36:41 4 A Correct.

01:36:41 5 Q Where did Ms. Mims tell Ms. Bayer -- at what  
01:36:48 6 point in the facility, what location, did she  
01:36:50 7 say, "I explained to her where [REDACTED] was"?

01:36:57 8 A I believe she stated that they were outside of  
01:37:00 9 the med room door.

01:37:03 10 Q What's the distance between the med room door  
01:37:05 11 and this particular bathroom?

01:37:11 12 A 20 feet.

01:37:12 13 Q So if Ms. Mims has now violated the policy of  
01:37:19 14 the facility and is 20 feet away from the door,  
01:37:23 15 was she fired for that?

01:37:26 16 A No.

01:37:26 17 Q Did she explain to you the next day why she  
01:37:31 18 walked 20 feet away from the bathroom door and  
01:37:35 19 left a resident unattended?

01:37:38 20 A She explained to me that she left the resident  
01:37:43 21 and told the oncoming shift that she was on the  
01:37:46 22 toilet, that she saw Jill nod her head in  
01:37:52 23 affirmation, and then she left her shift, and  
01:37:57 24 she believed that Jill was going to take over  
01:38:00 25 the care for this resident.

01:38:02 1 MR. CADE: Sam, would you read back  
01:38:03 2 my last question?

01:38:20 3 (Last question read.)

01:38:20 4 BY MR. CADE:

01:38:20 5 Q So, Ms. Barth, my question is far different.  
01:38:23 6 My question is you've already told me that it's  
01:38:26 7 a violation of the policy. I'm sure the policy  
01:38:30 8 doesn't say, "You get to walk 20 feet and  
01:38:33 9 orally tell somebody something and that's  
01:38:35 10 okay." You're supposed to wait or someone  
01:38:38 11 comes along and you say, "Hey, someone's in the  
01:38:41 12 bathroom, replace me." So explain to me why  
01:38:45 13 she walked 20 feet away from the resident and  
01:38:48 14 violated the policy and why she wasn't  
01:38:51 15 terminated for violating the policy. And that  
01:38:54 16 is compound.

01:38:59 17 A So I can't tell you why she did it. She did  
01:39:02 18 say that she did, and she was disciplined.

01:39:05 19 Q What discipline did she receive?

01:39:08 20 A She received a final warning and reeducation,  
01:39:12 21 as well as reeducation for all of our staff.

01:39:14 22 Q Okay. And what did that reeducation entail?

01:39:19 23 A The reeducation was done by the director of  
01:39:23 24 wellness and entailed not leaving residents  
01:39:27 25 unattended on a toilet.

01:39:29 1 Q Okay. Who was the director of wellness?

01:39:32 2 A Susan Marek.

01:39:36 3 Q Spell that last name.

01:39:37 4 A M-A-R-E-K.

01:39:41 5 Q So Ms. Marek had a meeting or explained -- did

01:39:47 6 she have a meeting, or did she circulate some

01:39:50 7 sort of documentation to the employees about

01:39:53 8 not leaving residents alone on the toilet?

01:40:00 9 A I'm unsure about how she in-serviced all of the

01:40:06 10 staff. I was not with her when she in-serviced

01:40:08 11 them.

01:40:08 12 Q Okay. Is there a reason why Mr. Grandberry

01:40:13 13 wasn't allowed the privilege of reeducation as

01:40:18 14 opposed to being terminated?

01:40:24 15 A Mr. Grandberry was terminated for a different

01:40:27 16 reason.

01:40:28 17 Q What different reason was he terminated for?

01:40:31 18 A For not knowing where a resident was and not --

01:40:37 19 for almost the entire amount of his shift from

01:40:40 20 3:00 p.m. until ten to 8:00 and not following

01:40:46 21 any type of a missing person protocol to look

01:40:51 22 for a resident or to notify a supervisor. That

01:40:56 23 was the reason for his termination.

01:40:58 24 Q As part of the reeducation, were the other

01:41:04 25 employees reminded that not only do you not

01:41:08 1 leave residents alone on the toilet, but you're  
01:41:11 2 supposed to follow up if a resident is not  
01:41:14 3 around or located?

01:41:18 4 A I don't have that in-service information in  
01:41:21 5 front of me. I don't know if it was included  
01:41:23 6 or not.

01:41:24 7 Q Okay. Would you agree with me that if  
01:41:35 8 Mr. Grandberry never heard -- let me back up.

01:41:41 9 Are there times -- again, I've got to  
01:41:52 10 fix myself.

01:41:53 11 When residents leave the facility  
01:42:00 12 from memory care, someone has to sign them out  
01:42:03 13 or there's some sort of note in the log they've  
01:42:06 14 been signed out, fair?

01:42:08 15 A Correct.

01:42:08 16 Q Are you aware of any instance prior to your  
01:42:18 17 becoming the director, the executive director,  
01:42:21 18 on September 18th of '17 where a resident left  
01:42:28 19 the building but there was no indication in a  
01:42:31 20 log book for them being signed out, like  
01:42:34 21 leaving with a family member or something of  
01:42:37 22 that nature or going to the doctor?

01:42:40 23 A I would have no idea if that happened before my  
01:42:42 24 employment.

01:42:43 25 Q Okay. Since your employment, has that ever

01:44:24 1 must check the log book at the beginning of a  
01:44:27 2 shift?

01:44:32 3 A I'm not aware that that is a policy that they  
01:44:35 4 have to check it at the beginning of a shift.

01:44:38 5 Q Okay. Is there a policy that says they're  
01:44:42 6 supposed to check it at the middle of a shift  
01:44:45 7 for whether a resident has been checked out?

01:44:47 8 A I'm not aware of a policy that states that.

01:44:50 9 Q What about at the end of the shift?

01:44:53 10 A No.

01:44:53 11 Q Is there any written policy that specifically  
01:44:58 12 states a caregiver is supposed to verify or  
01:45:03 13 look at the log book as to where a resident is  
01:45:07 14 if they're not present on the unit; that's the  
01:45:09 15 first place they're supposed to turn?

01:45:11 16 A Yes, if they're not present. That was not your  
01:45:14 17 question. If a resident is not present, that  
01:45:17 18 is a place that they would look. They would  
01:45:19 19 look at that log book to see if the resident  
01:45:23 20 was signed out.

01:45:23 21 Q And how long do they have to wait before they  
01:45:26 22 check the log book if the resident is not  
01:45:28 23 present?

01:45:28 24 A They should be checking that log book within  
01:45:33 25 ten minutes at least of beginning to look for a

01:45:36 1 resident who's been identified as not present.  
01:45:39 2 They should be looking for the resident and  
01:45:42 3 then using the log book, the sign-out book, as  
01:45:47 4 "We cannot find this resident, and so now I'm  
01:45:50 5 looking at the book to see if the resident has  
01:45:52 6 been signed out."

01:45:53 7 Q Okay.

01:45:53 8 A So that's -- that happens almost immediately  
01:45:58 9 after a -- a look throughout the unit.

01:46:03 10 Q So it's fair to say that, in this case,  
01:46:06 11 Ms. Bayer made a phone call to the resident's  
01:46:10 12 family before contacting any senior staff that  
01:46:15 13 [REDACTED] was missing, correct?

01:46:17 14 A Correct.

01:46:17 15 Q That's not an appropriate way to handle a  
01:46:21 16 missing resident, is it?

01:46:24 17 A It would be an appropriate way to handle, to  
01:46:26 18 call a family member, yes.

01:46:28 19 Q Okay. And who was responsible for  
01:46:32 20 [REDACTED]? Was it Ms. Bayer or  
01:46:35 21 Mr. Grandberry?

01:46:36 22 A Both of those people are assigned to -- were  
01:46:38 23 assigned to that unit. They are both  
01:46:41 24 responsible for all of the residents under  
01:46:42 25 their care.

01:46:43 1 Q Okay. With each shift, do you have multiple  
01:47:00 2 men -- let me rephrase.  
01:47:04 3 Do you have a male caregiver on every  
01:47:07 4 shift?  
01:47:09 5 A No.  
01:47:09 6 Q Okay. Do the caregivers often divide up who is  
01:47:18 7 responsible for certain residents? Well, I  
01:47:29 8 should ask --  
01:47:29 9 A It depends on the unit.  
01:47:31 10 Q On memory care, how many residents are there on  
01:47:34 11 average?  
01:47:35 12 A 13 residents in a neighborhood if a unit is  
01:47:39 13 full.  
01:47:40 14 Q Okay. And at that particular time on October 4  
01:47:45 15 of '17, how many residents were there?  
01:47:49 16 A I don't know. I'm not aware.  
01:47:52 17 Q Do the caregivers normally split up the  
01:47:57 18 residents, "You take this half, and I'll take  
01:48:00 19 that half"?  
01:48:01 20 A Yes, they would each take residents and would  
01:48:07 21 get them -- provide their cares, bring them to  
01:48:13 22 meals.  
01:48:13 23 Q Okay. So if Mr. Grandberry took responsibility  
01:48:17 24 for -- according to him he says, "I have four  
01:48:19 25 men, and I take the men and another resident,"



01:52:32 1 in front of me.

01:52:33 2 Q So you knew at one point; you don't know now?

01:52:39 3 A Correct.

01:52:39 4 Q How long ago was she terminated?

01:52:49 5 A I believe she was terminated a few months after  
01:52:52 6 this incident occurred, but I don't have the  
01:52:56 7 date.

01:52:57 8 Q Was it another incident that caused her  
01:53:00 9 termination?

01:53:01 10 A I'm sorry, I don't have the information in  
01:53:03 11 front of me.

01:53:05 12 Q Okay. If a resident is missing, the first  
01:53:21 13 thing the staff should do is look, correct?

01:53:24 14 A Correct.

01:53:25 15 Q Did Ms. Bayer ever tell Mr. Grandberry "I'm  
01:53:37 16 concerned about [REDACTED] we should start  
01:53:40 17 looking"?

01:53:45 18 A We can look at the statement that I have and we  
01:53:47 19 can tell that.

01:53:50 20 Q Which statement do you have?

01:53:53 21 A An exhibit, a statement that was submitted to  
01:53:57 22 the state. That would be the statement that  
01:54:01 23 would have been taken from Ms. Bayer at the  
01:54:05 24 time of the incident.

01:54:08 25 Q Again, this is your drafting of a statement,

01:58:43 1 Q Okay. What is the specific policy in terms of  
01:58:56 2 timing for employees -- or, I'm sorry, let me  
01:59:00 3 rephrase.

01:59:01 4 What is the specific policy in terms  
01:59:03 5 of timing for how often an employee is supposed  
01:59:07 6 to lay eyes on a resident?

01:59:12 7 A There is not a policy that says you need to lay  
01:59:15 8 eyes on someone every five minutes or ten  
01:59:18 9 minutes. There is no specific policy about a  
01:59:21 10 time.

01:59:21 11 Q So two hours could be fine and appropriate?

01:59:33 12 A It could be, depending on the resident and the  
01:59:36 13 location of the resident.

01:59:37 14 Q What do you mean, "the location of the  
01:59:39 15 resident"?

01:59:41 16 A If a resident is in memory care or a resident  
01:59:44 17 is in assisted living, so -- and it depends on  
01:59:49 18 the needs of the resident. So there's no  
01:59:53 19 policy that says for any particular resident  
01:59:56 20 with a particular diagnosis someone has to be  
02:00:00 21 observed on a certain interval of time. There  
02:00:05 22 is no policy like that.

02:00:06 23 Q So it's up to the company or you as the  
02:00:13 24 executive director for this specific facility  
02:00:17 25 to make a determination, "You should have seen

02:00:22 1 somebody inside of three hours or one hour," or  
02:00:24 2 whatever other time frame, correct?

02:00:25 3 A Correct.

02:00:26 4 Q Is there any training that's given, specific  
02:00:31 5 documents handed out saying, "These are the  
02:00:34 6 time frames by which we have expectations of  
02:00:37 7 you as employees"?

02:00:43 8 A I'm not aware of a document that states that.

02:00:47 9 Q What about training? Is there any training  
02:00:52 10 where you go over time frames? You know, "Hey,  
02:00:56 11 every half hour in memory care you have to  
02:00:59 12 watch out for somebody"?

02:01:02 13 A We don't have -- we don't have training that is  
02:01:06 14 very specific to an amount of time that goes  
02:01:10 15 between when you see a resident or how often  
02:01:13 16 you have to lay eyes on them. There's nothing  
02:01:15 17 that says every 30 minutes.

02:01:19 18 Q So if there's not a written policy, there's not  
02:01:23 19 even training, how is it that Mr. Grandberry is  
02:01:29 20 terminated for not laying eyes on [REDACTED]  
02:01:34 21 for approximately four hours and 50 minutes,  
02:01:39 22 give or take?

02:01:44 23 A It occurred because [REDACTED] didn't come to  
02:01:50 24 a meal, because she didn't get her medication,  
02:01:54 25 because Mr. Grandberry stated that he wondered

02:02:00 1 where she was, it was not like her not to be at  
02:02:03 2 a meal. So in his own words he stated that he  
02:02:10 3 didn't know where she was or why she wouldn't  
02:02:13 4 be there, and yet he took no action to try to  
02:02:16 5 locate her.

02:02:19 6 Q Who's responsible for passing out medications?

02:02:24 7 A Medication -- the medication aid, and that  
02:02:28 8 would have been Jill.

02:02:29 9 Q So when you made the statement that she wasn't  
02:02:33 10 there for her medications, that has nothing to  
02:02:37 11 do with Mr. Grandberry because that would have  
02:02:40 12 been Jill, right?

02:02:42 13 A Correct. It would have been Jill who would  
02:02:44 14 have given her her medications.

02:02:45 15 Q Okay. And did Jill raise her hand when you met  
02:02:48 16 with her and said, "I screwed up and didn't  
02:02:50 17 tell Mr. Grandberry that I couldn't find her or  
02:02:56 18 that she was missing"?

02:02:59 19 A No, Jill did not raise her hand and did not say  
02:03:03 20 that she screwed up and didn't tell James, no.

02:03:07 21 Q Okay. And who would be responsible for making  
02:03:11 22 sure that [REDACTED] was at her meal? Would  
02:03:16 23 that be Mr. Grandberry, or would that be  
02:03:19 24 Ms. Bayer?

02:03:20 25 A It would be both of the people who were on the

02:03:22 1 unit who are working.

02:03:24 2 Q Okay. So they both would go to her room and  
02:03:28 3 make sure that she gets down there, or would  
02:03:31 4 one handle it?

02:03:31 5 A Well, one would go and would get her or one  
02:03:37 6 would make sure, but it isn't an assignment as  
02:03:41 7 to who brings a resident to a meal.

02:03:47 8 Q Okay. So did you ask Ms. Bayer whether they  
02:03:50 9 had split responsibilities of who was supposed  
02:03:52 10 to bring [REDACTED] to the meal?

02:03:56 11 A No. There is not an official splitting of an  
02:03:59 12 assignment.

02:04:00 13 Q I understand that there's not an official,  
02:04:03 14 but --

02:04:03 15 A And I said no -- I said no, I did not, and I  
02:04:06 16 said there was not a splitting of the  
02:04:10 17 assignment. I said no.

02:04:11 18 Q Right, but --

02:04:13 19 A Thank you.

02:04:13 20 Q -- hear me out. And my question prior to that  
02:04:18 21 was kind of tongue in cheek, but, again, I said  
02:04:22 22 I assume they both don't go up to the room and  
02:04:25 23 get her; one person would be responsible,  
02:04:28 24 right?

02:04:29 25 A One person would go to get a resident.

02:08:25 1 Q I -- go ahead.

02:08:27 2 A The police -- the -- it was appropriate to call  
02:08:30 3 the police, it was appropriate to call 911, and  
02:08:34 4 it was appropriate to call the family. All of  
02:08:36 5 those things were appropriate.

02:08:39 6 Q Before contacting senior staff?

02:08:44 7 A I don't have a specific timeline that says who  
02:08:48 8 was contacted first. I think many things  
02:08:51 9 happened at the same time, and it isn't the  
02:08:55 10 timeline about who was contacted that was the  
02:08:59 11 issue. The issue resulting in termination was  
02:09:04 12 that the resident's whereabouts were unknown  
02:09:08 13 from 3:00 p.m. until ten to 8:00 when another  
02:09:12 14 staff person came down and helped to direct the  
02:09:16 15 search.

02:09:18 16 Q Calling the family and calling the police  
02:09:21 17 before contacting senior staff is outside of  
02:09:26 18 the normal procedures for the facility,  
02:09:28 19 correct?

02:09:31 20 A Calling the family would not be. If you have a  
02:09:35 21 document that you can show me that shows a  
02:09:38 22 timeline, I would appreciate it. Calling the  
02:09:41 23 family would be something that we would do if  
02:09:44 24 we could not -- if we were locating -- trying  
02:09:46 25 to locate a resident. That isn't something

02:09:49 1 that we would terminate an employee over,  
02:09:51 2 calling a family member.

02:09:53 3 Q Okay.

02:09:53 4 A We're trying to find a resident. The  
02:09:57 5 resident's whereabouts is most important.

02:09:59 6 Q I'm going to show you Exhibit 16. Do you have  
02:10:02 7 that up on the screen, ma'am?

02:10:06 8 A Yes.

02:10:06 9 Q And according to Exhibit 16, it is a resident  
02:10:11 10 checklist as of October 15, 2016. Do you see  
02:10:15 11 that?

02:10:16 12 A I do, hm-hm.

02:10:17 13 Q Okay. Prior to your appearance there, correct?

02:10:24 14 A Correct.

02:10:24 15 Q Have you modified this checklist?

02:10:29 16 A I haven't modified this. We don't use this.  
02:10:33 17 We're not a part of SLC any longer.

02:10:35 18 Q Okay. So three weeks into your employment, you  
02:10:39 19 would agree with me this checklist, Exhibit 16,  
02:10:42 20 is the appropriate checklist, correct?

02:10:45 21 A Correct.

02:10:45 22 Q So the first thing they're supposed to do is  
02:10:48 23 inform the front desk or someone they designee  
02:10:51 24 and say "Code Silver," right?

02:10:54 25 A Correct.

02:11:52 1 A Headquarters was not called.

02:11:54 2 Q No, no, it doesn't say calling headquarters.

02:11:57 3 The front desk is referred to as,

02:12:00 4 quote/unquote, "headquarters."

02:12:02 5 A Yes, the front desk was not called.

02:12:04 6 Q Okay. And then it says you're supposed to

02:12:07 7 notify the executive director or manager. Was

02:12:10 8 that done?

02:12:11 9 A It was done, and both Denys who was a

02:12:16 10 supervisor and Sue Marek were notified.

02:12:22 11 Q Were they notified before the family was called

02:12:23 12 or after?

02:12:24 13 A You must have an exhibit that states that.

02:12:32 14 Q I must have an exhibit that states what?

02:12:35 15 A Do you have an exhibit that states the order?

02:12:40 16 Q No, ma'am. I'm asking you. You told me at the

02:12:43 17 beginning of the deposition you had a

02:12:46 18 familiarity with Mr. Grandberry. You're the

02:12:49 19 one who did the investigation. You are the

02:12:50 20 executive director. So I am asking you based

02:12:52 21 on your prior statement that contacting the

02:12:55 22 family before senior staff was called was

02:12:57 23 appropriate. I'm going through the checklist

02:13:00 24 right now with you to verify each point.

02:13:04 25 Mr. Grandberry has testified that the



02:13:06 1 first thing that he knew was the police and the  
02:13:09 2 family showed up. Ms. Bayer contacted the  
02:13:15 3 family before contacting anyone on senior  
02:13:18 4 staff. So I'd like to know at what point it  
02:13:21 5 was appropriate for Ms. Bayer to contact the  
02:13:23 6 family and ignore the checklist. Or would you  
02:13:27 7 agree with me she ignored the checklist, called  
02:13:31 8 the family, and completely violated policy? We  
02:13:34 9 can cut this short if you'd like to do that.

02:13:42 10 A When -- my recollection of the incident is that  
02:13:46 11 when the resident -- it was determined that the  
02:13:49 12 resident was missing and action needed to be  
02:13:52 13 taken, which was approximately 7:45 p.m., that  
02:13:59 14 a number of things happened fairly  
02:14:02 15 simultaneously, including staff helping to try  
02:14:05 16 to locate the resident, that the supervisor,  
02:14:10 17 Denys, was called, that James was on the phone  
02:14:16 18 with Denys, and at the time that they were on  
02:14:20 19 the phone, that the resident was located and  
02:14:23 20 they were directed to call 911.

02:14:27 21 The police were then called, 911, and  
02:14:32 22 the ambulance. The police and the ambulance  
02:14:35 23 both came to the building, and the family had  
02:14:39 24 been called to see if the resident was with  
02:14:42 25 them. I'm aware that one daughter was called.

02:14:45 1 She said, "My mother is not with me." She  
02:14:47 2 called another daughter. They said the mother  
02:14:49 3 was not with them. Then the family came to the  
02:14:52 4 building.

02:14:53 5 The family arrived, the police  
02:14:56 6 arrived, the paramedics arrived, and I don't  
02:15:03 7 know minute by minute in what order or exactly  
02:15:06 8 a very specific timeline. I believe all of  
02:15:08 9 those things happened almost simultaneously  
02:15:12 10 when it was decided the situation was serious  
02:15:14 11 and the resident was gone, and that was after  
02:15:19 12 four hours and approximately 45 or 50 minutes  
02:15:24 13 of not knowing or having any -- any -- having  
02:15:29 14 eyes on this particular resident.

02:15:31 15 Q Okay. So, again, I'm going to come back and  
02:15:35 16 I'm going to go through your checklist and ask  
02:15:38 17 you the questions.

02:15:39 18 A Hm-hm.

02:15:39 19 Q If the front desk was not notified, were you  
02:15:47 20 notified as the executive director prior to  
02:15:50 21 anything else, prior to the family being  
02:15:53 22 called, the police showing up, ambulance,  
02:15:55 23 whatever? Were you notified?

02:15:59 24 A No. I was notified as all of that was taking  
02:16:02 25 place. I was notified in the midst of all of

02:16:05 1 that taking place.

02:16:06 2 Q The police had already shown up by the time you  
02:16:09 3 were notified, correct?

02:16:10 4 A The -- I was sitting at my desk and I saw the  
02:16:14 5 police and the fire department coming by, and I  
02:16:16 6 went down after -- at the same time I received  
02:16:20 7 a call from the director of wellness saying  
02:16:22 8 that there was a situation with a resident, and  
02:16:26 9 I ran down to the building.

02:16:27 10 Q Okay. So, Ms. Barth, I'll ask my question  
02:16:30 11 again. The police were contacted before you  
02:16:32 12 were, correct?

02:16:33 13 A Correct.

02:16:34 14 Q Okay. Because even if you dial 911 for the  
02:16:38 15 police to show up, it still will take a minute,  
02:16:42 16 two minutes minimum for them to appear, fair?

02:16:44 17 A Yes, that's correct.

02:16:48 18 Q Okay. And I don't see anywhere on this  
02:16:49 19 checklist -- and I can turn to the next page if  
02:16:52 20 you'd like -- where it says anything about  
02:16:54 21 "simultaneous." "Call the police but  
02:16:57 22 simultaneously call the executive director."  
02:17:00 23 It doesn't say that anywhere, does it? Do you  
02:17:02 24 want me to flip to the next page?

02:17:06 25 A Go ahead.

02:18:32 1 Q I mean, in fact, 1, 2, 3, 4 lines before  
02:18:37 2 calling the police, you're supposed to notify  
02:18:39 3 legal; call the lawyers before you call the  
02:18:42 4 police, right?

02:18:44 5 A Wrong.

02:18:45 6 Q "Legal counsel notified"? Do you see that,  
02:18:49 7 ma'am?

02:18:51 8 A If we have a resident that is laying on the  
02:18:54 9 floor, we will call 911, and the ambulance will  
02:18:59 10 arrive. That is to meet the needs of the  
02:19:04 11 resident. The police were an escort. They  
02:19:09 12 escorted the ambulance. The resident was on  
02:19:16 13 the floor. It is policy and it is appropriate  
02:19:18 14 that if a resident is laying on the floor that  
02:19:20 15 we would -- the staff would call 911 to attend  
02:19:23 16 to the resident's medical needs before  
02:19:26 17 following a checklist.

02:19:28 18 Q I understand that, Ms. Barth, and that's --  
02:19:32 19 thank you for that. My point was on your  
02:19:36 20 checklist, when someone is missing, before the  
02:19:40 21 police are called, legal is one of the things  
02:19:45 22 called. When [REDACTED] was found, the  
02:19:48 23 police had already been notified, correct?

02:19:52 24 A At the time that 911 was called, they were  
02:19:58 25 called because she was on the ground and she

02:20:00 1 was on the floor and she needed medical  
02:20:02 2 attention. We would never call the legal  
02:20:05 3 department before calling 911 to attend to a  
02:20:09 4 resident's medical need.

02:20:10 5 Q Well, and, see, there you jumped the gun  
02:20:13 6 because I didn't say "you" meaning the facility  
02:20:16 7 called. Ms. Bayer called the family, and the  
02:20:22 8 family called the police, right?

02:20:26 9 A The -- that is not my understanding of what  
02:20:29 10 happened. The family -- it is not my  
02:20:31 11 understanding that the family called the  
02:20:33 12 police. It is my understanding that our staff  
02:20:35 13 called 911 and the police escorted the  
02:20:39 14 ambulance to the site.

02:20:42 15 Q So when [REDACTED] -- when the search began,  
02:20:54 16 Denys, whether she was an RN or LPN, was  
02:20:57 17 involved in the search, correct?

02:20:59 18 A No. She would have been on the telephone. She  
02:21:02 19 was not there in person.

02:21:03 20 Q Okay. Why would they have been on the phone  
02:21:08 21 with Denys and not with you as executive  
02:21:10 22 director when you're the second name or the  
02:21:13 23 second thing on the checklist?

02:21:20 24 A At the time that they were on, they notified --  
02:21:26 25 they notified the nurse, and at the same time

02:22:43 1 happened very quickly and simultaneously when  
02:22:46 2 they decided to look for the resident. The  
02:22:49 3 resident was found on the ground. They made  
02:22:52 4 the right decision to attend to the medical  
02:22:55 5 needs of the resident before doing anything  
02:22:57 6 else.

02:22:58 7 They followed -- so they began the  
02:23:02 8 search. They just began the search five hours  
02:23:06 9 too late. The search should have happened on  
02:23:11 10 a -- at a number of other points during the  
02:23:14 11 shift that they were working when they could  
02:23:17 12 not locate and knew that they didn't know where  
02:23:19 13 [REDACTED] was. When they made the  
02:23:24 14 discovery, they did the right thing to call the  
02:23:26 15 supervisor and 911 and to have paramedics come  
02:23:31 16 to manage her medical needs.

02:23:34 17 Q What manager was on duty at the time that  
02:23:37 18 [REDACTED] went missing?

02:23:39 19 A The manager on duty would always be the nurse  
02:23:47 20 who would be the primary nurse for that  
02:23:49 21 building. We don't have a specific designation  
02:23:53 22 of someone being a manager on duty on a piece  
02:23:57 23 of paper. The manager of the building is  
02:24:00 24 always the person, the nurse -- it's always the  
02:24:03 25 person that attends to and answers that first

02:24:05 1 line of medical needs. I am not a nurse.

02:24:07 2 Q Other than Ms. Bayer and Mr. Grandberry, who

02:24:12 3 else was physically present from the facility

02:24:15 4 when the search began?

02:24:16 5 A A caregiver named Elicia who had come from the

02:24:24 6 upstairs -- one of the upstairs units. She

02:24:27 7 assisted with the search.

02:24:32 8 Q Spell her name.

02:24:33 9 A E-L-I-C-I-A.

02:24:38 10 Q Do you have Elicia's last name?

02:24:40 11 A A-L-O-N-S-O. I -- I -- I believe that is how

02:24:54 12 it's spelled.

02:24:55 13 Q I'm sorry, could you spell that again?

02:24:58 14 A A-L-O-N-S-O, first name E-L-I-C-I-A.

02:25:02 15 Q Alonso is the last name?

02:25:06 16 A Yes, A-L-O-N-S-O.

02:25:09 17 Q And what document are you looking at for that

02:25:12 18 information?

02:25:12 19 A I'm looking at your Exhibit 00134 for the

02:25:18 20 spelling of her name.

02:25:19 21 Q My exhibit? I don't have an Exhibit --

02:25:22 22 MR. SWINICK: Bates number.

02:25:23 23 MR. CADE: Sure.

02:25:29 24 BY MR. CADE:

02:25:30 25 Q Did you interview Elicia, Ms. Alonso, in terms

02:25:34 1 of what she saw or was aware of before you  
02:25:37 2 terminated Mr. Grandberry?

02:25:39 3 A Yes, I did.

02:25:40 4 Q Did you obtain a statement from her?

02:25:43 5 A She typed a statement and gave me a statement.

02:25:45 6 Q Okay. Does it have a Bates number?

02:25:52 7 A I don't know. Is that -- I don't know.

02:25:53 8 Q It's a number at the bottom. You'll see it  
02:25:58 9 says "SLHV," and then it has numbers. Is there  
02:26:03 10 a SLHV number for her statement?

02:26:12 11 A I don't know. Do you have it?

02:26:14 12 Q I'm asking you the question, ma'am. You're  
02:26:18 13 reading -- you have a statement in front of  
02:26:21 14 you, and I'm asking you about Elicia's  
02:26:24 15 statement.

02:26:24 16 A Yes. 00135.

02:26:27 17 Q Other than Ms. Alonso, was there anybody else  
02:26:40 18 present who assisted with the search prior to  
02:26:45 19 [REDACTED] being located?

02:26:52 20 A I don't have the names of other people that  
02:26:55 21 would have helped. There would have been two  
02:26:58 22 other people on the first floor --

02:26:59 23 Q Okay.

02:27:01 24 A -- and they were aware of the resident when it  
02:27:03 25 was identified, and they started to look for



02:27:06 1 her.

02:27:07 2 Q Who else would be present? You said there was  
02:27:15 3 those two other people?

02:27:16 4 A Right. There would have been two staff over on  
02:27:19 5 the other side, on the other unit.

02:27:22 6 Q Okay. Was Ms. Alonso terminated for not  
02:27:39 7 following the checklist?

02:27:42 8 A No, she wasn't.

02:27:44 9 Q Is Ms. Alonso, was she -- what race is she, if  
02:27:52 10 you know?

02:27:52 11 A African American.

02:27:54 12 Q Okay. Now, according to her statement -- I'll  
02:28:09 13 pull that up -- she indicates -- let me throw  
02:28:16 14 that up -- it's Bates No. SLHV00135 -- "I came  
02:28:26 15 downstairs through the front stairs because the  
02:28:28 16 elevator was not working properly." She ran  
02:28:32 17 into Tynisia, T-Y-N-I-S-I-A, sitting on the  
02:28:37 18 couch. At some point, according to her, Jill  
02:28:41 19 comes running in and says she essentially can't  
02:28:45 20 find [REDACTED], so Ms. Alonso asked Tynisia to go  
02:28:53 21 with her to check outside on the patio and the  
02:28:57 22 garden. Do you see that?

02:28:59 23 A Yes.

02:28:59 24 Q Is that part of the checklist to go check on  
02:29:02 25 the patio, or should they have contacted the

02:29:05 1 front desk first?

02:29:06 2 A At this point they are looking to see if they  
02:29:11 3 can locate the resident.

02:29:12 4 Q That wasn't my question, ma'am. My question  
02:29:15 5 was an either/or. Should they have gone  
02:29:19 6 looking, or should they have contacted the  
02:29:22 7 front desk?

02:29:25 8 A They should have looked for the resident to  
02:29:29 9 determine if the resident was missing.

02:29:31 10 Q Okay. She then found another woman, Tasha,  
02:29:43 11 T-A-S-H-A, and they look outside on the patio.  
02:29:48 12 "We checked all the rooms/bathrooms and didn't  
02:29:51 13 find nobody on the cottage side." Was she  
02:29:53 14 missing at that point? Was [REDACTED]  
02:29:55 15 missing at that point once they've now checked  
02:29:58 16 rooms/bathrooms and "didn't find nobody on the  
02:30:01 17 cottage side"?

02:30:04 18 A They're looking for her to determine if she's  
02:30:07 19 missing.

02:30:07 20 Q Okay. Well, I'm trying to figure out at what  
02:30:11 21 point someone is missing. If you're going  
02:30:14 22 through and looking in various rooms, right --  
02:30:16 23 and [REDACTED] in a wheelchair, so I would  
02:30:19 24 imagine she can't go through the garden very  
02:30:22 25 easily on her own, right?

02:30:28 1 A Possibly, yes.

02:30:29 2 Q Right. I mean, it's not like I'm missing or  
02:30:32 3 you're missing. It's someone in a wheelchair  
02:30:34 4 who needs assistance. So at what point in time  
02:30:41 5 is she missing such that they're supposed to  
02:30:44 6 contact the front desk?

02:30:48 7 A If they were following this, she would have  
02:30:51 8 been missing about four hours earlier and they  
02:30:57 9 would have started this whole process  
02:31:00 10 immediately and not four, almost five hours  
02:31:05 11 later.

02:31:05 12 Q Right, but I'm trying to figure out -- see,  
02:31:09 13 you're -- I appreciate your statement, and we  
02:31:11 14 can go past the three o'clock hour. I'm trying  
02:31:15 15 to figure out once they start looking in rooms  
02:31:17 16 and bathrooms and they can't find anybody, is  
02:31:21 17 she missing? That's a yes/no.

02:31:24 18 A They found her, and so they immediately asked  
02:31:31 19 for medical involvement, which was appropriate  
02:31:34 20 to do, before anyone was called, before I was  
02:31:37 21 called. They found her, and she was on the  
02:31:39 22 ground. It would have been irresponsible for  
02:31:42 23 them to call me to ask about calling the  
02:31:45 24 paramedics. We have a situation where a  
02:31:47 25 resident is in medical need, and they called

02:31:50 1 911 which was the proper procedural thing to  
02:31:55 2 do.

02:31:55 3 Q Ms. Barth, Mr. Swinick is more than able to  
02:31:59 4 make those statements on your behalf. Again,  
02:32:02 5 I'll come back to and I'll stay on this as long  
02:32:04 6 as I have to. You would agree with me that the  
02:32:07 7 cottage is not the same place as the memory  
02:32:10 8 care area, right?

02:32:11 9 A The cottage is the memory care area.

02:32:14 10 Q Okay.

02:32:15 11 A It is a neighborhood in memory care. I do not  
02:32:17 12 agree with you.

02:32:18 13 Q Okay. So "I proceeded to go by cottage and  
02:32:21 14 found Tasha, and I looked outside on the patio  
02:32:24 15 in the cottage. We checked all the  
02:32:27 16 rooms/bathrooms and didn't find nobody on the  
02:32:30 17 cottage side." Well, [REDACTED] was found in  
02:32:34 18 a bathroom, right?

02:32:35 19 A That's been established.

02:32:37 20 Q Okay. And if they checked all the rooms and  
02:32:40 21 the bathrooms, either Ms. Alonso is lying or  
02:32:46 22 they never checked the one bathroom because the  
02:32:48 23 door was locked, fair?

02:32:51 24 A That's not fair, no.

02:32:52 25 Q Okay.

02:32:53 1 A That's incorrect.

02:32:55 2 Q Well, then how can she check all of the rooms

02:33:00 3 and the bathrooms and "didn't find nobody on

02:33:03 4 the cottage side"?

02:33:04 5 A There are two neighborhoods. There is a

02:33:06 6 cottage side, and there's a garden side.

02:33:09 7 Q Okay.

02:33:09 8 A The resident was found on the garden side, not

02:33:13 9 on the cottage side. They share a living room

02:33:15 10 area.

02:33:16 11 Q So if they are searching and on the cottage

02:33:22 12 side she's checked all of the rooms and the

02:33:26 13 bathrooms, at that point should Ms. Alonso have

02:33:31 14 said, "Hey, [REDACTED] missing"?

02:33:38 15 A I've already given you my statement. They

02:33:40 16 found the resident, and they indicated that she

02:33:45 17 was on the floor, and they called 911. I have

02:33:47 18 no other statement to make other than that.

02:33:49 19 Q Well, I'll ask it again, ma'am, and I

02:33:52 20 appreciate that.

02:33:52 21 A Okay.

02:33:52 22 Q Let's read the next sentence.

02:33:54 23 A Okay.

02:33:54 24 Q "Tasha and I came back to the cottage. The

02:33:58 25 door to the bathroom off the kitchen was

02:35:15 1 A Correct.

02:35:16 2 Q And I'm asking before they said, "What about  
02:35:18 3 that bathroom," and opened the door, when they  
02:35:20 4 went through the cottage side and checked  
02:35:22 5 everything and didn't find her, was she missing  
02:35:25 6 at that point? That's a yes or no. Either she  
02:35:28 7 was missing or she wasn't missing.

02:35:30 8 A She was missing. She -- her location -- they  
02:35:39 9 did not know her location. They did not know  
02:35:41 10 her location a long time before that incident  
02:35:44 11 occurred and they were looking for her.

02:35:46 12 Q Okay. So should Ms. Alonso have been -- should  
02:35:53 13 she have contacted the front desk and said  
02:35:56 14 "Silver Alert" or whatever the code word is to  
02:35:59 15 alert folks that [REDACTED] was missing?

02:36:03 16 A It is my opinion that she was doing the right  
02:36:06 17 thing by looking for the resident before they  
02:36:09 18 alerted someone because they were doing their  
02:36:13 19 sweep, their search of the unit, the  
02:36:17 20 neighborhoods. They were doing their sweep,  
02:36:19 21 and they were attempting to locate the  
02:36:24 22 resident. They found the resident, and they  
02:36:28 23 asked for 911 assistance to take her to be  
02:36:33 24 medically examined.

02:36:34 25 Q I'm looking at Exhibit 16 which is the

02:46:03 1 Q I'm going to show you a document, Bates 127  
02:46:20 2 through 140.

02:46:21 3 MR. CADE: And, Sam, we'll mark this  
02:46:25 4 as Exhibit 19.

02:46:27 5 (Exhibit No. 19 was marked.)

02:46:31 6 BY MR. CADE:

02:46:32 7 Q Ma'am, I'd like to turn to -- we'll go through  
02:46:39 8 a couple of documents. First apparently is an  
02:46:40 9 e-mail dated February 11th, 2018, on Sunday  
02:46:43 10 that you sent to DHS Caregiver Intake for the  
02:46:50 11 State of Wisconsin; is that correct?

02:46:52 12 A Correct.

02:46:52 13 Q And according to this document, there was a  
02:46:58 14 self-report on October 9 of 2017, correct?

02:47:06 15 A Yes, correct.

02:47:08 16 Q So let's go over the -- it says there are three  
02:47:12 17 individual caregivers. Let's go over that.

02:47:14 18 A Okay.

02:47:14 19 Q "Misconduct Incident Report." It indicates  
02:47:19 20 that "Kim Mims placed," redacted, [REDACTED] "on  
02:47:23 21 the toilet in the restroom next to the kitchen  
02:47:23 22 on the garden neighborhood. At the time of  
02:47:25 23 shift change" -- well, let me ask you this:  
02:47:28 24 Did [REDACTED] have her own bathroom?

02:47:32 25 A She would have had a bathroom, yes.

02:48:56 1 A Are you talking about this report that we're  
02:48:58 2 looking at right now?

02:48:59 3 Q Yes, ma'am.

02:49:00 4 A I did.

02:49:00 5 Q Okay. I don't see in the description of the  
02:49:06 6 incident where you indicate that according to  
02:49:08 7 this the other second shift caregiver would  
02:49:11 8 have overheard the conversation as to the  
02:49:14 9 location of [REDACTED].

02:49:16 10 A This is the -- this is the misconduct incident  
02:49:22 11 report that is specific to Ms. Mims. This is  
02:49:26 12 not an incident report specific to anyone other  
02:49:31 13 than Ms. Mims and what her part is in the  
02:49:35 14 incident.

02:49:35 15 Q Okay. Well, let's go to the next page.

02:49:38 16 A Okay.

02:49:38 17 Q Up at the top it says it's Page 4 of 9. What  
02:49:57 18 would be Pages 1, 2, and 3?

02:50:00 19 A Directions on how to fill out the report.

02:50:02 20 Q Okay. And where on here -- so according to  
02:50:38 21 this report, Bates 132, Mims again says she  
02:50:46 22 left her at the end of her shift at 3:00 p.m.  
02:50:52 23 "She stated she informed the oncoming p.m.  
02:50:56 24 caregiver, Jill Bayer, who was in the dining  
02:50:57 25 room that the resident was on the toilet in the



02:51:00 1 bathroom next to the dining room. She gave her  
02:51:03 2 a nod. During the investigation, the p.m.  
02:51:07 3 caregiver stated that she was not told the  
02:51:10 4 resident was on the toilet." So I come back to  
02:51:16 5 my question. If, in fact, Ms. Mims lied about  
02:51:24 6 informing Ms. Bayer as to [REDACTED]'s  
02:51:27 7 location, should Ms. Mims have been terminated  
02:51:31 8 for lying?

02:51:32 9 A I was not -- if someone lied about a situation,  
02:51:38 10 that would be grounds for termination. It was  
02:51:41 11 not determined that she lied.

02:51:43 12 Q You made a judgment call on who was telling the  
02:51:48 13 truth?

02:51:51 14 A I made a judgment call that it could not be  
02:51:54 15 determined if it was a lie or not a lie or if  
02:51:59 16 Ms. Bayer had heard or had not heard. I did  
02:52:02 17 make that decision, yes.

02:52:07 18 Q Okay. "At approximately 7:55 p.m., the p.m.  
02:52:11 19 caregiver called the family and learned the  
02:52:13 20 resident was not with them." That was not part  
02:52:19 21 of the checklist, correct?

02:52:28 22 A That was -- that is a precursor to the  
02:52:31 23 checklist to determining if a resident is  
02:52:34 24 missing.

02:52:34 25 Q To call the family?

02:52:40 1 A If you're looking for the whereabouts of a  
02:52:42 2 resident, you can call the family. That is  
02:52:45 3 permissible to call the family to see if they  
02:52:48 4 have the resident or not.

02:52:49 5 Q Because according to the checklist, while  
02:53:00 6 you're searching outside, at some point you're  
02:53:03 7 supposed to notify the POA or responsible  
02:53:09 8 party, and, I'm sorry, I don't see in the  
02:53:10 9 checklist where it says to call the --  
02:53:13 10 actually, it says down at the bottom,  
02:53:16 11 "POA/responsible party notified." Do you see  
02:53:19 12 that, three from the bottom on Exhibit 16?

02:53:23 13 A Yes, I do.

02:53:24 14 Q Okay. So they can skip 15 other procedures and  
02:53:34 15 call the family first and say, "We're looking  
02:53:39 16 for [REDACTED]; do you have her?" That's  
02:53:42 17 appropriate?

02:53:46 18 A At this point they are doing a sweep of the  
02:53:49 19 building to determine now that -- if the  
02:53:51 20 resident is missing. If it is determined that  
02:53:54 21 the resident is missing and nobody knows where  
02:53:57 22 she is, then we follow these steps that are  
02:54:01 23 listed on this sheet. So they are doing the  
02:54:06 24 sweep at this point trying to determine her  
02:54:09 25 location and if she is a missing person.

02:54:13 1 Q That wasn't an answer to my question. The  
02:54:18 2 checklist is supposed to be followed other than  
02:54:21 3 if someone's on the floor and you have to call  
02:54:23 4 911, medical attention, but if someone is  
02:54:27 5 missing, you start with the very first thing  
02:54:30 6 and work your way down the checklist, right?

02:54:36 7 A If we're reading the checklist the way you are,  
02:54:39 8 that is correct. If you're reading the  
02:54:41 9 checklist to make the determination about  
02:54:43 10 whether the person is missing or the person can  
02:54:47 11 be found, you start with a sweep of the  
02:54:50 12 building which is before any of the missing  
02:54:52 13 person checklist is initiated.

02:54:55 14 Q Okay. So now you're giving the employees  
02:54:59 15 discretion before they follow the checklist?  
02:55:03 16 Is that what you're saying?

02:55:04 17 A Absolutely not.

02:55:05 18 Q So if they do a sweep -- because if they do a  
02:55:10 19 sweep, that's a thorough search of the  
02:55:12 20 building, right?

02:55:12 21 A That is not what I'm saying, and, no, that is  
02:55:15 22 not correct.

02:55:15 23 Q A sweep is not a thorough search?

02:55:19 24 A It says "Once the community has identified a  
02:55:21 25 missing person." At this point in the process,

02:55:26 1 they decided to start looking for the resident,  
02:55:29 2 and they are looking for the resident. They  
02:55:33 3 found the resident, so officially we've not  
02:55:37 4 called a Silver Alert. The police were called,  
02:55:41 5 the fire department was called because we are  
02:55:44 6 attending to her medical needs.

02:55:46 7 Q I get that. So --

02:55:48 8 A Okay.

02:55:48 9 Q -- if, then, just so I can understand this --

02:55:54 10 A Okay.

02:55:54 11 Q -- at the time the family is called, it's okay  
02:56:05 12 to contact them to verify that she's not with  
02:56:09 13 the family, fair?

02:56:12 14 A That is a correct statement.

02:56:14 15 Q So if it's okay to verify with the family that  
02:56:20 16 she's not there and we're not starting at the  
02:56:26 17 beginning of our missing person checklist,  
02:56:30 18 then, in fact, she's not a missing person at  
02:56:33 19 that point, is she?

02:56:46 20 A Would you like to rephrase that for me?

02:56:56 21 Q No, I think I stated it pretty good. I'll ask  
02:56:58 22 Sam to read it back because I think I made my  
02:57:01 23 point, but...

02:57:01 24 (Last question read.)

02:57:22 25 THE WITNESS: Okay. We have a

02:57:23 1 missing person. We have a resident that has  
02:57:25 2 not been seen since the beginning of a shift.  
02:57:32 3 It's determined that at a certain time, 7:50,  
02:57:38 4 that nobody knows where she is. It is  
02:57:41 5 appropriate to call the family and to ask, and  
02:57:45 6 at the same time, other things were happening.  
02:57:48 7 So I'm happy to move on from here. I'm happy  
02:57:53 8 to answer a yes or a no. I've explained the  
02:57:56 9 policy, I've explained the procedure, and I've  
02:57:59 10 explained the timeline for this situation.

02:58:03 11 BY MR. CADE:

02:58:04 12 Q Well, no --

02:58:05 13 A I'm telling you I can't tell you more than  
02:58:08 14 that.

02:58:08 15 Q We will continue, ma'am. Thank you.

02:58:11 16 A Okay.

02:58:11 17 Q Because if she's missing, the point of the  
02:58:14 18 missing person checklist is to follow the  
02:58:17 19 checklist as written. You don't get to pick  
02:58:20 20 and choose what part of the checklist you want  
02:58:23 21 to follow and don't follow, right?

02:58:28 22 A You would follow a policy; you would follow a  
02:58:30 23 procedure; you would follow a checklist.

02:58:32 24 Q Okay.

02:58:33 25 A The --

02:58:33 1 Q And it doesn't say on this checklist, unless  
02:58:37 2 there's -- is there a written policy or is  
02:58:38 3 there a training manual somewhere that says,  
02:58:40 4 "If someone is missing, call the family first,  
02:58:45 5 other than what's identified here third from  
02:58:48 6 the bottom, "POA/responsible party notified"?  
02:58:53 7 Is there some other list that I'm not aware of  
02:58:55 8 that says, "Yeah, she's -- you don't know where  
02:58:59 9 she is; go ahead and call the family first  
02:59:02 10 before going through your checklist"?  
02:59:05 11 A That is part of the initial protocol if you're  
02:59:08 12 looking for a resident. This missing policy --  
02:59:11 13 missing person policy and talking and calling  
02:59:15 14 the family is -- in a situation where you've  
02:59:20 15 done your sweep of the building, you've done  
02:59:22 16 your search, you can't find a resident, you use  
02:59:28 17 this missing resident checklist to make all the  
02:59:31 18 right calls.  
02:59:36 19 Q But Jill hasn't done a sweep. She didn't do  
02:59:40 20 any of that. She called the family. She said,  
02:59:43 21 "I haven't seen her." There's no testimony  
02:59:45 22 that Jill did a sweep. And, again, I don't  
02:59:49 23 see, so tell me where I'm missing, where it  
02:59:52 24 says, "Employee, you have discretion to call  
02:59:56 25 the family first." If they're not missing,

03:01:11 1 building or not.

03:01:12 2 Q Where on here does it say "conduct a sweep of  
03:01:16 3 the building"?

03:01:17 4 A It would be prior to determining that the  
03:01:19 5 resident was missing. You don't declare a  
03:01:22 6 missing resident before you've done a sweep of  
03:01:26 7 the building, all of the rooms to determine if  
03:01:29 8 you can find the resident. Once that's done  
03:01:34 9 and it's determined that a resident is missing,  
03:01:36 10 you go to the missing resident policy, and this  
03:01:39 11 is the policy; this is the checklist that's  
03:01:41 12 used. In doing the sweep of the building, of  
03:01:46 13 the units, of the rooms, the resident was  
03:01:51 14 located. So --

03:01:53 15 Q According -- I'm sorry. Go ahead.

03:01:55 16 A That's -- I don't have anything else to say.

03:01:58 17 Q According to this policy, there also should be  
03:02:02 18 a camera review where applicable. Is there a  
03:02:06 19 camera?

03:02:07 20 A There's a camera -- there is a camera. The  
03:02:10 21 camera is located at the back outside door.

03:02:14 22 Q Is there a camera inside the facility?

03:02:17 23 A No.

03:02:17 24 Q Turning back to Exhibit 19, "The p.m. caregiver  
03:02:37 25 wondered where the resident was during the

03:02:41 1 course of the shift but thought the family must  
03:02:44 2 have taken her out." Was she missing at that  
03:02:46 3 point if she thought she was with the family?  
03:02:55 4 A I can't tell you if -- I can't tell you what  
03:02:58 5 she thought or what she didn't think.  
03:03:02 6 Q But that's not my question.  
03:03:05 7 A You asked me if I thought if she thought. I'm  
03:03:09 8 telling you I don't know what she thought.  
03:03:12 9 Q I can have Sam read it back.  
03:03:12 10 A Okay.  
03:03:14 11 Q I read the statement, and I said, "Was she  
03:03:17 12 missing at that point? So Jill has made a  
03:03:22 13 determination. "I haven't seen her all day. I  
03:03:27 14 thought she was out with the family." And if  
03:03:29 15 she hasn't seen her all day and thought she was  
03:03:32 16 with the family, was she missing?  
03:03:34 17 A Jill should have looked for her at that time to  
03:03:39 18 determine if she was missing or not missing.  
03:03:44 19 At any moment during the course of that shift  
03:03:46 20 when either she or Mr. Grandberry didn't know  
03:03:51 21 her whereabouts or thought it was unusual for  
03:03:53 22 her not to be at a meal, they should have  
03:03:57 23 looked for her to determine if she was a  
03:03:59 24 missing resident or not.  
03:04:04 25 Q What time is dinner served?



03:04:07 1 A I would assume -- now it's served at  
03:04:09 2 approximately 4:30. I would assume it was  
03:04:13 3 served at about 4:30. I don't think it's  
03:04:16 4 changed much in the years.

03:04:17 5 Q Why was Ms. Mims given a final written  
03:04:35 6 counseling on October 11th, a week after the  
03:04:38 7 incident?

03:04:39 8 A She didn't work before that. That's when --

03:04:42 9 Q She went a full week without work?

03:04:44 10 A That's when we saw her next, I believe.

03:04:46 11 Q According to Ms. Alonso, Mr. Grandberry  
03:05:19 12 contacted Sue. That would be Sue Marek,  
03:05:21 13 correct?

03:05:23 14 A Correct.

03:05:24 15 Q Is that appropriate if someone is missing to  
03:05:27 16 contact Sue Marek, a supervisor?

03:05:31 17 A She was the director of wellness. It would be  
03:05:34 18 appropriate for them to call. If they are in  
03:05:39 19 the midst of trying to locate a resident, it  
03:05:43 20 would be appropriate for them to call, yes.

03:05:45 21 Q Would that be appropriate during the sweep  
03:05:48 22 while you're trying to determine if they're  
03:05:49 23 missing or once you've made a determination  
03:05:52 24 they're missing?

03:05:53 25 A It would be appropriate at either of those

03:05:56 1 times.

03:05:57 2 Q Sue Marek made a statement as well, correct?

03:06:12 3 A Correct.

03:06:12 4 Q Who is Janelle, according to Jill Bayer's  
03:06:38 5 statement? It says "I asked Janelle for an  
03:06:46 6 update," J-A-N-E-L-L-E. Ms. Barth, who is  
03:07:03 7 Janelle?

03:07:03 8 A I -- I believe she is a caregiver. I know she  
03:07:08 9 was a caregiver. I don't know what shift she  
03:07:13 10 was working on that day.

03:07:16 11 Q Okay. So if it says "I asked Janelle for an  
03:07:22 12 update," did Janelle get terminated?

03:07:33 13 A No, Janelle did not get terminated.

03:07:36 14 Q Did you get a statement from Janelle?

03:07:43 15 A I don't have a statement from Janelle. Janelle  
03:07:46 16 was not involved in this incident.

03:07:49 17 Q Well, but if Jill called Janelle and said,  
03:07:54 18 "Where is [REDACTED]" doesn't that mean that  
03:07:56 19 she's involved?

03:08:05 20 A I don't know what assignment Janelle had or  
03:08:07 21 what unit she worked on or where she was. She  
03:08:10 22 was not working on the night of the incident.  
03:08:18 23 I don't have a report in front of me that says  
03:08:20 24 when she was working.

03:08:21 25 Q Well, I do, Exhibit 11. Janelle Tatum, October

03:08:26 1 4th. Let's see if I can read exactly what that  
03:08:36 2 says. What does "M" stand for?

03:08:43 3 A I believe med passer.

03:08:44 4 Q Okay. And then there's some handwriting or  
03:08:48 5 something next to that. Do you know what that  
03:08:50 6 means?

03:08:50 7 A I don't know.

03:08:52 8 Q As the med passer, that would be the same thing  
03:09:04 9 as Mr. Grandberry -- I'm sorry, as Ms. Bayer.  
03:09:11 10 You're supposed to -- I mean, the med passer is  
03:09:13 11 looking at every single one of the residents,  
03:09:16 12 correct?

03:09:18 13 A The med passer is responsible like everybody  
03:09:22 14 else, but that med passer is responsible for  
03:09:25 15 passing meds to whomever has medications.

03:09:29 16 Q Okay. I am looking on this exhibit, ma'am.  
03:09:33 17 What does the "X" mean?

03:09:40 18 A Tell me where.

03:09:41 19 Q Well, Mr. Grandberry has an "X," and it says  
03:09:47 20 the 5th he's off, but the day that he's working  
03:09:50 21 3:00 to 11:00, it says "X."

03:09:57 22 A I can't tell you. I don't know what the "X" --  
03:09:59 23 if I look at this, it would appear that he was  
03:10:03 24 not the med passer, and "M" would be the person  
03:10:06 25 who's passing meds. The "X" would be the

03:10:10 1 person who is working but not passing meds.

03:10:14 2 Q So the "X" would not necessarily go to every  
03:10:18 3 resident to hand medication, correct?

03:10:22 4 A The "X" would not hand medication to anybody.

03:10:26 5 Q Did [REDACTED] need medication?

03:10:34 6 A I believe she was on medication, but I don't  
03:10:36 7 have a medication list for her in front of me.  
03:10:40 8 I don't know. I don't recall what medications  
03:10:44 9 she might have been getting.

03:10:46 10 Q According to Ms. Bayer, she said "BF is still  
03:11:08 11 on half-hour checks." Who is "BF"?

03:11:11 12 A A resident.

03:11:13 13 Q A specific resident?

03:11:16 14 A Yes. Those would be the initials of a  
03:11:22 15 resident.

03:11:22 16 Q Okay. So "I asked Janelle for an update," and  
03:11:26 17 is it Janelle told her that BF is on the  
03:11:29 18 half-hour checks, or is it Jill telling Janelle  
03:11:32 19 the half-hour checks?

03:11:34 20 A I -- I can read it the same as you can. "I  
03:11:39 21 asked Janelle for an update. She said BF is  
03:11:43 22 still on half-hour checks."

03:11:43 23 Q Right, except these are your notes. So it's  
03:11:46 24 not Jill's exact statement; it's your notes,  
03:11:49 25 and your notes --

03:26:22 1 A You have my notes, and this is what I  
03:26:24 2 documented. So, yes, that would be correct.  
03:26:29 3 I -- this is exactly what I did.

03:26:33 4 Q Were you present as an employee as the  
03:27:01 5 executive director when Mr. Grandberry was  
03:27:03 6 having issues with his pay stubs and he was not  
03:27:10 7 being compensated for work?

03:27:12 8 A No, I believe that was before my time, before I  
03:27:15 9 was there as the director.

03:27:17 10 Q Fair enough. Give me one second, ma'am.

03:28:01 11 MR. CADE: Those are my questions.

03:28:08 12 MR. SWINICK: Nothing from me.

03:28:12 13 MR. CADE: Thank you, Ms. Barth.

14 (Proceedings concluded at 3:28 p.m.)

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1       STATE OF WISCONSIN    )  
                                          ) SS:  
2       COUNTY OF MILWAUKEE )  
3  
4

5                       I, SAMANTHA J. SHALLUE, a Registered  
6       Professional Reporter and Notary Public in and for  
7       the State of Wisconsin, do hereby certify that the  
8       above Zoom deposition of DEBRA BARTH was recorded by  
9       me on December 22, 2020, and reduced to writing  
10      under my personal direction.

11                     I further certify that I am not a  
12      relative or employee or attorney or counsel of any  
13      of the parties, or a relative or employee of such  
14      attorney or counsel, or financially interested  
15      directly or indirectly in this action.

16                     In witness whereof I have hereunder set  
17      my hand and affixed my seal of office at Milwaukee,  
18      Wisconsin, this 4th day of January, 2021.  
19  
20  
21

22                                               \_\_\_\_\_  
                                              Notary Public  
23                                               In and for the State of Wisconsin  
24  
25

My Commission Expires: June 3, 2023.



Exhibit 3

AM 40/40  
16/16  
PM 24/24  
16/16  
NOC 40/40

# Harbour House

## GARDEN

OCTOBER OF 2017

Staff	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	10/1	10/2	10/3	10/4	10/5	10/6	10/7	10/8	10/9	10/10	10/11	10/12	10/13	10/14
7:00 a.m. - 3:00 p.m.														
A Weshuna Love	OFF	X	X	X	X	OFF	M	M+2nd-C	X	2nd	M	X	X	OFF
B Janell Tatum	M	M	OFF	M-10R	M-10R	M	M	2nd	M-10R	M	M	X	OFF	M+2nd
A Kim Mims	X	OFF	X	OFF	OFF	X+2nd	OFF	OFF	OFF	X	OFF	OFF	X	X
B NEED EOW 16/16	OFF	OFF	OFF	OFF	OFF	OFF	OFF	Tasha-1	OFF	OFF	OFF	OFF	OFF	OFF
3:00 p.m. - 11:00 p.m.														
B James Grandberry	X	X	X	X	OFF	S/S	OFF	OFF	X	X	X	OFF	X	X
A Jill Bayer	M-9	M	M	M	M	OFF	M	M	M	OFF	M	M	M	OFF
A 24/24 NEED PT	OFF	OFF	OFF	OFF	Tasha	Tasha	OFF	Janell 1-9	OFF	Shuna-9	OFF	Tasha	OFF	Janell-9
B NEED EOW 16/16	OFF	OFF	OFF	OFF	OFF	OFF	NEED	OFF	OFF	OFF	OFF	OFF	OFF	OFF
11:00 p.m. - 8:00 a.m.														
A Kim Young	X	OFF	OFF	OFF	OFF	X	OFF	OFF	X	X	OFF	OFF	OFF	X
B 40/40 NEED FT	OFF	Jessica-6:30	NEED	Jessica-6:30	OFF	OFF	Bessie	Jessica-6:30	OFF	OFF	NEED	Bessie	Bessie	OFF

Sr. Resident Assistant  
Need/Open Shift  
M Medication Passer for Floor  
M Medication Passer in Household  
X Help Set Up Large Activity and do Small Activity  
Large Group Activity  
M-T Med Train

A Americana  
W Woodlands  
C Cottage  
G Garden  
CI Call In

F Float between floors  
T Shadow Training  
V Vactaion  
S/S Switched Shift

Dietary and AL CBRF Training 9:00-5:00p  
Skill and Core Training 1:00p



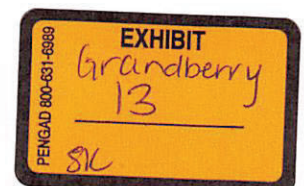
Statement by James Grandberry  
Taken by Debra Barth, Executive Director  
Re: Incident with REDACTED on 10/4/17

I am responsible for most of the men. We have 4 men. I take the men and resident R\*\*. Jill helped me with residents R\*\* and C\*\*. At 2:45 PM I started talking with Sue (Director of Wellness), talking about the job and people working. At 3 PM I came to the Unit. Girls were in the office (med room). I talked to them and they were getting ready to leave. Jill was doing (med) count and I went into activities. Played games, talking, singing, being happy. Then it was time for dinner. I pushed people in, set up tables. I was like, where's REDA. Jill said, 'She must be out.' She said, 'I don't know why she's out and they (day shift) didn't give her meds.' Usually family doesn't take her out, they usually visit. I didn't think anything about it. I got through cleaning the kitchen, took people to activities, took Millie to the other building, took garbage out. Jill says it seems kind of strange that REDAC out and no one's called. I had no idea that she was in the bathroom. I find it strange that she was in there. I didn't look at the 24 hour report, usually the med passer does. I'm in activity. Jill first started asking about Loretta around 4:45 -5 PM. We didn't make calls to supervisors. I thought it was strange that REDAC wasn't here. She never misses a meal, even when she's sick she still eats slowly. When her daughter's come and take her to a doctor visit she's usually back.

Jill said, 'I hope they're fixing a plate.' She said, 'They could have told us.' I said, 'It's strange she's not here.' I started opening doors. Instead of looking, Jill called the family. There was lots of commotion. I asked when the last time she was toileted.

(After the EMTs arrive) Jill was talking to the police. She said so and so left her on the toilet. Sue (Director of Wellness) was on my phone. I gave the phone to Jill. (Someone) said to Jill, 'You're talking too much. What you should have done first is look before you call the family.' We should have laid eyes on everyone.

*James Grandberry*  
10/4/17



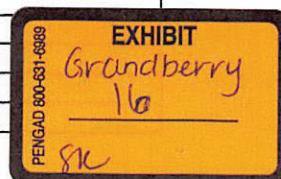




Senior Lifestyle Corporation  
1.7.8.1 Missing Resident Checklist rev. 10/15/16  
(To be attached to an SLC Incident Report)

Community: \_\_\_\_\_ Resident's Name: \_\_\_\_\_  
Apt #: \_\_\_\_\_ Date: \_\_\_\_\_ ☐ Resident suspected as missing ☐ Door alarm sounding/Resident missing

Item	Date/Completed By	Comments
Once the community has identified a missing resident, inform the front desk and/or designee by stating "Code Silver" and the room number of the missing person.		
Front desk and/or designee will be in charge of the initial search and will be referred to as Headquarters. The front desk or designee will notify the Executive Director and a manager on if the Executive Director is not present at the time of the event.		
If alarm is activated- Alarm silenced after Executive Director/ manager on-duty and Security notified		
The Executive Director or Manager on Duty will assign 2 team members to search the community perimeter and one team member to search the missing residents room.		
Resident head count and systematic room search to be initiated.		
The front desk will review Sign-out Log & the Health and Wellness Director, Memory Care Director or designee will review the 24 Hr. Report to determine if the resident is out of the building.		
The Program Director, Memory Care Director or designee should also review other program outing sign-out sheets that may show an outing event is taking place.		
Thorough search inside of community		
Thorough search outside of community		
Notify Local Management Personnel (On-duty personnel to notify Managers)		
HWD, MCD or DON notified		
ED/Administrator notified		
Where applicable camera review		
Notify Regional/Divisional/HO Personnel (*Notification to be done by ED/ALD or Administrator/DON)		
RDO/VP of OPs notified*		
RDHW/ Clinical OPs notified*		
Call Significant Event line (this is to report and is not a form of immediate contact.		
Risk Management notified**		
Legal Counsel notified**		
COO/CEO notified**		
POA/Responsible party notified*		
Attending physician notified*		
Local authorities/police notified*		



Consider activating "Silver Alert"*		
Organize search teams		
Provide all search teams with information for resident identification		
Check with family, friends and local establishments/places resident goes		
Check local transport companies		
Re-check inside and outside community		
Expand search to neighborhood within a two mile radius		
Expand search further, as directed		
Upon return to facility, exam resident and provide treatment as necessary		
HWD//DON notify attending physician of return, obtain and follow orders		
Notify POA/Resp. party of return*		
Notify search teams of return		
Implement intervention to prevent any further occurrence in service plan.		
Institute a 24-hour monitoring schedule of the resident.		
Notify State Regulatory Agency as per State regulatory guidelines		
RDHW to review before submitting		
Complete documentation		
SLC Incident Report/Send to H.O.		
Documentation in resident chart		

Personnel are not authorized to speak to the media without the express consent of the VP/RDO. Updated 10/15/2016

Scott Walker  
Governor



Linda Seemeyer  
Secretary

State of Wisconsin  
Department of Health Services

DIVISION OF QUALITY ASSURANCE

1 WEST WILSON STREET  
PO BOX 2969  
MADISON WI 53701-2969

Telephone: 608-266-8481  
Fax: 608-267-0352  
TTY: 711 or 800-947-3529

April 04, 2018

CONFIDENTIAL

James Grandberry  
4606 N. 41<sup>st</sup> St.  
Milwaukee, WI 53209

COPIED

Dear Mr. Grandberry:

The Division of Quality Assurance, Office of Caregiver Quality (OCQ), is responsible for receiving, investigating and acting upon complaints of alleged misconduct by noncredentialed caregivers. Caregiver misconduct includes abuse or neglect of a client, or misappropriation of a client's property.

Our office received a report on February 12, 2018, alleging that caregiver misconduct occurred at The Harbour House, on or about October 04, 2017. Based on a review of the information currently available, OCQ will not conduct an investigation of the alleged incident at this time. However, if additional information becomes available, this case could be opened at a later date. Information about this report is considered confidential and will not be released to the public.

This determination does not affect, negate, or resolve other violations or regulatory enforcement actions that may have been issued or taken by the Department, nor does it affect, negate, or resolve employment issues relating to possible work rule violations.

If you have questions regarding this notice, please call 608-261-8319 or write to the address above.

Sincerely,

*Laurie Arkens*

Laurie Arkens, Director  
Office of Caregiver Quality

LA: as

cc: The Harbour House  
File 65310





## Debra Barth

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**From:** Debra Barth  
**Sent:** Sunday, February 11, 2018 1:19 PM  
**To:** dhscaregiverintake@dhs.wisconsin.gov  
**Cc:** Debra Barth  
**Subject:** Harbour House F62447 - 3 reports for 1 incident  
**Attachments:** K.Mims F62447.pdf; J.Grandberry F62447.pdf; J. Bayer F62447.pdf

Please find attached 3 Misconduct Incident Reports for 3 individual caregivers of Harbour House, 5900 Mockingbird Lane, Greendale, WI 53129.

There was an incident on 10/4/17 related to a resident.

A self-report was sent to the Bureau of Assisted Living, Southeastern Regional Office on 10/9/17.

Misconduct Incident Reports were not submitted as the investigation found there was no criminal intent and no intentional actions on the part of the caregivers involved.

On 1/31-2/1/18, there was a State Survey at Harbour House related to this self-report.

The surveyors felt that Misconduct Incident Reports should have been filed.

I am submitting the 3 reports along with investigation documentation now.

Please contact me if more information is required.

Debra Barth, Executive Director  
414-750-5922

Harbour House  
5900 Mockingbird Lane  
Greendale, WI 53129

Debra Barth  
Executive Director

Harbour Village  
5700 Mockingbird LN  
Greendale, WI 53129

414-433-9302  
[seniorlifestyle.com](http://seniorlifestyle.com)



Embrace **life**.  
Embrace **moments**.  
Embrace **connection**.

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## MISCONDUCT INCIDENT REPORT

Completion of this form is required by Wis. Admin. Code § DHS 13.05(3)(a). Failure to file a complete and accurate report of an incident of alleged misconduct, as required, may subject the entity to forfeiture or other sanctions specified by the Department under § DHS 13.05(3)(e) and may delay the investigation process. Personal information will be used to investigate the reported incident and the results of the investigation may be shared with other authorized investigative agencies.

**This report form must be completed in its entirety. Additional information may be attached.**

**TYPE OR PRINT NEATLY IN BLACK INK.**

### I. ENTITY INFORMATION

Name – Entity or Facility

Harbour House

Federal Provider or Certification No.

State License, Approval, or Registration No.

Entity Type Code (*See instructions.*)

83

Street Address

5900 Mockingbird Lane

City

Greendale

County

Milwaukee

State

WI

Zip Code

53129

Name – Administrator

Debra Barth

Telephone No.

414-421-9600

### II. SUMMARY OF INCIDENT

**INDICATE** when the incident occurred. If the exact date and time are unknown, make a reasonable estimate and indicate that the date and time are estimated. Include the date the incident was discovered, if other than the date the incident occurred.

Date Occurred (MM/dd/yyyy)

10/04/2017

Time Occurred

2:50 PM

Date Discovered (MM/dd/yyyy)

10/04/2017

**BRIEFLY DESCRIBE THE INCIDENT** in the space below. Summarize the incident here even if additional documentation is attached.

At approximately 2:50 PM on 10/4/17, caregiver Kim Mims placed resident **REDACTED** on the toilet in the restroom next to the kitchen on the Garden neighborhood. At the time of shift change, Ms. Mims stated she informed the 2<sup>nd</sup> shift caregiver that Ms. **REDACTED** was on the toilet and the caregiver nodded in what she took to be an acknowledgement. Ms. Mims left her shift and did not personally take Mrs. **REDACTED** off of the toilet. Mrs. **REDACTED** was found laying on the floor of the bathroom next to the toilet at approximately 7:55 PM.

**DESCRIBE THE EFFECT** that the incident had on the affected person, the person's reaction to the incident, and the reaction of others who witnessed the incident.

Mrs. **REDACTED** was transported to the hospital. There was no physical injury and she was returned to Harbour House by EMT at 1:15 AM on 10/5/17. Mrs. **REDACTED** did not exhibit any signs of distress upon her return.



**EXPLAIN** what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct.

Harbour House took the following actions in response to this incident:

- Harbour Houses employees were re-educated on the Missing Person Response Procedure,
- the two PM employees were terminated from employment for not following the Missing Person Response Procedure,
- Ms. Mims, who left the resident on the toilet at the end of the shift, has been re-educated to finish providing care prior to leaving the shift and recieved a final written counseling,
- HarbourHouse employees were re-educated to complete providing care fot residents prior to leaving at the end of a shift.

**CHECK** the specific location where the incident happened.

☒ At Your Entity ☐ During Transport ☐ Another Location – *Explain.*

### III. AFFECTED PERSON INFORMATION (If more than one, include additional pages.)

Name – Affected Person <b>REDACTED</b>	Date of Birth (MM/dd/yyyy) <b>REDACTED</b>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Telephone No. NA	
Address 5900 Mockingbird Lane		City Greendale	State WI	Zip Code 53220

If the affected person is adjudicated incompetent, under age 18, or has an authorized Power of Attorney for Health Care, include the name, address, and telephone number of parent, guardian, or legal representative.

Name - Parent, Guardian, or Power of Attorney			Telephone No. <b>REDACTED</b>	
Address <b>REDACTED</b>		City <b>REDACTED</b>	State <b>RE</b>	Zip Code <b>REDACTED</b>

### IV. ACCUSED PERSON INFORMATION (If more than one, include additional pages.)

Name – Accused Person (if known) Kim Mims	Date of Birth (MM/dd/yyyy) <b>REDACTED</b>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Home Telephone No. 414-484-3325	
Position, Title, or Relationship to Affected Person (at the time of the incident) caregiver			Social Security No. <b>REDACTED</b>	

☒ Non Credentialed Staff ☐ Credentialed Staff ☐ Resident ☐ Other (Specify.)

List any known credential held by accused at time of incident; e.g., RN, LPN, social worker, security guard, professional counselor.  
none

Home Street Address 331 W. Hadley	City Milwaukee	State WI	Zip Code 53212
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**NOTE: If employer is other than the reporting entity, provide information about accused person's current employer.**

Name – Employer		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No.	
Street Address		City	State	Zip Code

**NOTE: If accused person is under 18, provide parent(s) or guardian information.**

Name(s) – Parent or Guardian		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No.	
Street Address		City	State	Zip Code



**V. LAW ENFORCEMENT INVOLVEMENT**

Was law enforcement contacted or involved?

☐ No ☒ Yes If "yes," complete the following. Attach copy of the law enforcement incident report, if available.

Name – Officer (if available) Officer Dibbs		Telephone No. 414-423-2121	
Name – Department Greendale Police Department		Case No. (if available)	
Street Address 5911 W. Grange Ave.	City Greendale	State WI	Zip Code 53129

**VI. PERSONS WITH SPECIFIC KNOWLEDGE OF THE INCIDENT** *If more space is necessary, attach additional pages.*

Name – Person who REPORTED Incident to the Entity Erica Alonso		Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Telephone No.
Street Address	City	State	Zip Code

Is this person an ENTITY EMPLOYEE? ☐ Yes ☒ No

Position in the Entity or Relationship to the Affected Person: Caregiver

Name – Person with Information About the Incident Susan Marek		Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Telephone No. 262-352-8659
Address 4430 Patricia Lane	City Waukesha	State WI	Zip Code 53186

Is this person an ENTITY EMPLOYEE? ☐ Yes ☒ No

Position in the Entity or Relationship to the Affected Person: Was employed as Director of Wellness at time of incident

Name - Person with Information About the Incident James Grandberry		Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No. 414-215-3450
Address 4606 N. 41 <sup>st</sup> St.	City Milwaukee	State WI	Zip Code 53209

Is this person an ENTITY EMPLOYEE? ☒ Yes ☒ No

Position in the Entity or Relationship to the Affected Person: Mr. Grandberry was employed by the entity at the time of the incident. He was one of two second shift employees termed

Name - Person with Information About the Incident Jill Bayer		Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Telephone No. 414-467-4466
Address 4419 S. 20 <sup>th</sup> St.	City Milwaukee	State Wi	Zip Code 53221

Is this person an ENTITY EMPLOYEE? ☐ Yes ☒ No

Position in the Entity or Relationship to the Affected Person: Ms. Bayer was employed by the entity at the time of the incident. She was one of two second shift employees termed

Name - Person with Information About the Incident Debra Barth		Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Telephone No. 414-570-5922
Address 5700 Mockingbird Lane	City Greendale	State WI	Zip Code 53129

Is this person an ENTITY EMPLOYEE? ☒ Yes ☐ No

Position in the Entity or Relationship to the Affected Person: Executive Director of Harbour House



**VII. DESCRIBE BELOW OR ATTACH COPY OF ENTITY'S INVESTIGATIVE RECORDS CONCERNING INCIDENT.**

On 10/4/17, **REDACTED** resident of Harbour House, 5900 Mockingbird Lane, Greendale, WI 53129, had a fall from the toilet that she was seated on in the bathroom near the main dining room. Mrs. **REDA** was transported to the hospital at approximately 8:30 PM and was returned to Harbour House at approximately 1:15 AM on 10/5/17. No injuries were sustained as a result of the fall.

Mrs. **REDACT** DOB is **REDACT**. She has diagnosis of **REDACTED**

**REDACTED** She has been a resident of Harbour House since 05/06/16.

An investigation into the fall found that Mrs. **REDACT** was placed on the toilet at approximately 2:50 PM by the day shift caregiver Kim Mims. Ms Mims left at the end of her shift, at 3 PM. She stated she informed the oncoming PM caregiver Jill Bayer, who was in the dining room that the resident was on the toilet in the bathroom next to the dining room. According to Kim Mims, the PM caregiver gave her a nod which she took as acknowledgement. During the investigation, the PM caregiver stated she was not told the resident was on the toilet. The PM caregiver wondered where the resident was during the course of the shift but thought the family must have taken her out. At approximately 7:55 PM, the PM caregiver called the family and learned that the resident was not with them. An immediate search of the neighborhood was conducted and the resident was found lying on the bathroom floor.

911 was called to the facility for transport. Greendale Police officer Dibbs also responded to the scene. He initially thought there was an unruly patient, however realized that was not the case. After arriving her thought he may have been called because of the caregiver who was very emotional or to determine if there was criminal intent. He did not believe there was any criminal intent.

Ms. Mims was given a Final Written Counseling on 10/11/17 for leaving a resident on a toilet and leaving her shift without finishing cares. Ms. Mims documented on the correction notice, "After I put resident on the toilet I had a conversation with my second shift co-worker notifying her that the resident had been toileted that she would need to get her off."

**VIII. PERSON PREPARING THIS REPORT (TYPE or PRINT neatly in BLACK INK.)**

Name - Person Preparing This Report Debra Barth		Telephone No. 414-750-5922	Email Address Debrab@seniorlifestyle.com	
Street Address 5700 Mockingbird Lane		City Greendale	State WI	Zip Code 53129
Is this person an ENTITY EMPLOYEE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Position in the Entity or Relationship to the Affected Person: Executive Director				
SIGNATURE - Person Preparing This Report Debra Barth			Date Signed (MM/dd/yyyy) 2/10/18	



ASSISTED LIVING & MEMORY CARE ONLY - INCIDENT / OCCURRENCE REPORT  
CONFIDENTIAL - NOT TO BE MADE PART OF RESIDENT MEDICAL RECORD OR RESIDENT  
Community Name: Garden - HH

I. INCIDENT / OCCURRENCE

Individual Involved  
Name: REDACTED

APT#:

DOB: REDACTED

Age: REDACTED

Incident Date:

10-4-2017

Incident Time:

1:00 PM  
I came down stairs @ 08:12

Reported By: Erica R. Alonso

Witnesses: Tasha Ramos

III. NATURE OF INCIDENT / OCCURRENCE

Use this box ONLY if incident was due to FALL - was fall:  
☐ Witnessed OR ☐ Un-witnessed  
If resident hits head call 911. If resident refuses 911, have them sign Refusal of Treatment/Transport form. If fall is un-witnessed, resident has hit head, begin Head Injury Monitoring.  
☐ Bathroom, NOT in shower  
☐ Bathroom, in shower  
☐ Resident Apt. NOT at bedside  
☐ Other: ☐ Resident Apt. at bedside  
☐ Outside: parking lot, walkway  
☐ Common Area:

II. INJURY / COMPLAINTS

TYPE OF INJURY / COMPLAINT

- ☐ None Apparent  
☐ Bruise  
☐ Cut  
☐ Bleeding  
☐ Pain  
☐ Skin Tear  
☐ Swelling  
☐ Burn  
☐ Numbness  
☐ Non-responsive  
☐ Choked  
☐ Other:

BODY PART AFFECTED

- ☐ Scalp / Skull  
☐ Nose  
☐ R Eye  
☐ L Eye  
☐ R Ear  
☐ L Ear  
☐ Jaw  
☐ Mouth  
☐ Teeth  
☐ Other / Head  
☐ Neck  
☐ Spine  
☐ Chest  
☐ Abdomen  
☐ Genitalia  
☐ Back (when found)  
☐ Other:  
☐ Pelvis  
☐ Other / Trunk  
☐ R Shoulder  
☐ L Shoulder  
☐ R Upper Arm  
☐ L Upper Arm  
☐ R Elbow  
☐ L Elbow  
☐ R Forearm  
☐ L Forearm  
☐ R Wrist  
☐ L Wrist  
☐ R Hand  
☐ L Hand  
☐ R Finger  
☐ L Finger  
☐ R Hip  
☐ L Hip  
☐ R Buttock  
☐ L Buttock  
☐ R Thigh  
☐ L Thigh  
☐ R Knee  
☐ L Knee  
☐ R Lower Leg  
☐ L Lower Leg  
☐ R Ankle  
☐ L Ankle  
☐ R Foot  
☐ L Foot  
☐ R Toe  
☐ L Toe

MEDICATION ERROR:

- ☐ Wrong Drug  
☐ Wrong Dosage  
☐ Wrong Route  
☐ Med name / mg.  
☐ Wrong Resident  
☐ Wrong Time  
☐ Missed Dose  
☐ Pharmacy Error  
☐ Discontinued Drug

Elopement:

- ☐ On Premises  
☐ Without Injury  
☐ Door Alarm Activated? ☐ NA ☐ Yes ☐ No  
☐ Off Premises  
☐ With Injury

Transfer / Transport of Resident:

- ☐ Injury Transferring Resident  
☐ Injury Transporting Resident

OTHER

- ☐ Resident to resident contact:  
☐ Unexplained bruising / Injury  
☐ Other:  
☐ Witnessed  
☐ Un-witnessed  
☐ Theft of money or property

IV. TREATMENT REQUIRED

- Transferred for treatment?  
☐ EMS/911 ☐ Family ☐ Staff ☐ Where: ☐ Yes ☐ No

V. NOTIFICATION / ORDERS

- Name of Nurse Notified: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Nurse's Instructions: Fill out Incident Report, S  
Name of Director Notified: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Family Member / Authorized Rep.: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Name of Physician Notified: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Physician Instructions: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

VI. FACTS OBSERVED AT SCENE

SEE TYPED PAPER ->

VII. REVIEW / DISPOSITION

- Resident Disposition: ☐ Remained in Residence ☐ Hospitalized ☐ Returned to Residence ☐ Death ☐ Moved out ☐ Other  
☐ Resident Re-assessed  
☐ Service Plan Updated  
☐ Staff In-Serviced  
☐ 72 Hour Documentation started  
☐ Resident Refusal to Transport signed  
☐ Outside Consultation  
☐ Resident Counseling  
☐ Staff Disciplinary Action  
☐ Risk Agreement signed  
☐ 24 Hour Log updated  
☐ Head Injury Monitoring  
☐ Management Review  
☐ Procedure Review  
☐ Elopement Risk Review  
☐ Falls Risk Review  
☐ Referred to Therapy  
☐ Other

Name and title of person completing report: Erica R. Alonso, caregiver  
AL/LC/Dept Director reviewed / signature: \_\_\_\_\_  
Executive Director reviewed / signature: \_\_\_\_\_  
Comments / Resolution / Outcome / Final Disposition: \_\_\_\_\_

Date: 10-8-17  
Date: 10-9-17  
Date: \_\_\_\_\_

VIII. ADMINISTRATIVE AND REQUIRED NOTIFICATIONS

- ☐ State agency notified as appropriate by ED, ALD, LCD or other individual  
☐ RDO  
☐ PQS  
☐ WPO  
☐ Significant Event Line Called & Faxed Report  
Phone / Fax / Email  
Other:  
Initials: \_\_\_\_\_  
Time: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone / Fax / Email  
Other:  
Initials: \_\_\_\_\_  
Time: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone / Fax / Email  
Other:  
Initials: \_\_\_\_\_  
Time: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone / Fax / Email  
Other:  
Initials: \_\_\_\_\_  
Time: \_\_\_\_\_  
Date: \_\_\_\_\_



Name and title of persons who assisted

Erica R. Alonso

Date

10-8-2017

What did the resident state was their intent or reason for the fall?

n/a

Was the resident (please circle one)

Lowered to the ground

Discovered when already on the ground

Location of resident when discovered (please circle all that apply)

Their own room

Next to bed

By their wheelchair

In the bathroom

In the hallway

In a room other than their own room (please describe in detail)

Bathroom off Kitchen in garden

Position resident was in when discovered (circle all that apply)

Lying on back

Lying face down

Lying on side

Right / Left

Sitting on buttocks

Resting on knees

Other (please describe in detail)

Activity by resident prior to fall (please circle one)

Lying in bed

Sitting by bed side

Sitting in W/C

Sitting on commode/toilet

Transferring

Ambulating: Where was the resident going?

Other (please describe in detail)

If sitting in a W/C, did resident have (please circle all that apply)

Anti-lock brakes

Tip bars on W/C

Were the brakes locked YES / NO

A W/C cushion?

YES

NO

Was a gait belt used at the time of fall?

YES

NO

Was the personal alarm (pendant) on resident or in place?

YES

NO

Does the resident wear glasses?

YES

NO

Were their glasses on?

YES

NO

What type of footwear was on resident at the time of fall (circle one)

Grippy socks / Regular socks

Slippers / Shoes

No footwear

Any recent medication changes?

YES

NO

Was the resident reaching for a personal item when they fell?

YES

NO

Was the resident's device to call for help within reach?

YES

NO

If yes, please describe the item

I don't know!

NAME and TITLE of person completing this form

Erica R. Alonso

Date

10-8-17

I came downstairs thru the front stairs because the elevator was not working properly. I came in thru the door and Tynisia was sitting on the couch. A resident had just left and she went to her room in the Cottage. As I was walking thru Jill came running out stating "I can't find REDA she hasn't been here the whole shift, I've looked in all the rooms I can't find her and I called her daughter to see if she was with them." Jill was panicking and very concerned. I asked Tynisia can you please go with me to check outside on the patio in the Garden. The door was open to the patio. Tynisia and I walked outside, we found nobody. I proceeded to go by Cottage and found Tasha and I looked outside on the patio on the Cottage. We checked all the rooms, bathrooms and didn't find nobody on the Cottage side. Tasha and I came back to the Cottage. The door to the bathroom off the kitchen was closed. The fan was on you could hear it. We (Tasha and I) asked Jill if she checked the bathroom, she had said no. "We never use that bathroom, only in emergencies. (Jill said) Tasha had the keys and opened the door. REDA was found lying on the floor. She was fidgeting with her depend. There was James on the phone with Sue and Tasha was on the phone was Denys. I (Erica) told Tasha to hang up with Denys so 911 could be called. That was more important at this time. The first people to respond was Loretta's daughter and husband I believe. They were mixed with emotions seeing REDA on the floor of the bathroom. Jill was talking and telling the family that 1<sup>st</sup> shift put her on the toilet and never took her off. Again Jill was in panic mode. James was still on the phone was Sue. (I didn't hear any conversation). The next to arrive was Ems unit. There were several people including a police officer. The police officer was documenting the incident. The police officer told Jill "to stop talking". I proceeded to go back upstairs to my household.

Erica P. Alonso

**Debra Barth**

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**From:** AT&T <suzymarek@ameritech.net>  
**Sent:** Wednesday, October 04, 2017 10:50 PM  
**To:** Debra Barth  
**Subject:** Investigation

James called me and told me that they had a resident missing and they thought she was out with her family all night but it was not written on the 24 hr report so I asked who the resident was and he told me **REDA**. I said when was the last time you saw her and he said they never did that she was gone when they got there so they assumed she was out with family. Denys called me on my other phone so I was on the phone with James and Denys together and they stated they found her "she's on the floor in the bathroom off of the dining room." I asked if she was ok. They said yes and Denys directed them to call 911. James called me and stated Jill was "freaking out" and I asked James to put her on the phone because I could hear her screaming. I told her I needed her to be quiet now because I heard her yelling "this is first shifts fault" and she did not listen and kept yelling so I told her she needed to shut her mouth because she was speaking out of line and that she was responsible for this resident also. James grabbed the phone and said people were there and he would have to call me right back.

Sue Marek

Sent from my iPhone



Statement by Jill Bayer

Taken by Debra Barth, Executive Director

Re: Incident with REDACTED on 10/4/17

The last time I saw REDACTED was yesterday when I put her to bed. Usually she is sitting in the hub participating in activities. She was not there when I came in. My routine is to come in, go through every room to see where everyone is. I have everyone accounted for every single day. I said, "Where's REDACTED?" I did not get report from 1<sup>st</sup> shift. I asked Janelle for an update. She said BF is still on ½ hour checks and resident D\*\* might be coming back Thursday. She told me in the hallway outside the med room. I went about my business, checked in on everybody. I got ready for med pass. I asked where REDACTED was. I was nagging everyone about where REDACTED was. The consensus was that she was out, with Tasha and James. I called her family and asked them what time they were bringing her back. I talked to Ann. She called her sister. She called me back and said she wasn't with her sister. So we started searching every room. Tasha, Erica, James, Tsanta. I think Erica found her in the bathroom. The family was on the way over. She was laying on the floor. Her pants were half on, half off. There was a big BM in the toilet. There was no blood. She said she had to go to the bathroom. Her wheel chair was in the locked position, so someone put her in the bathroom. She didn't eat supper. I don't know why I didn't call.

J. Barth  
10/4/17

Statement by James Grandberry  
Taken by Debra Barth, Executive Director  
Re: Incident with [REDACTED] on 10/4/17

I am responsible for most of the men. We have 4 men. I take the men and resident R\*\*. Jill helped me with residents R\*\* and C\*\*. At 2:45 PM I started talking with Sue (Director of Wellness), talking about the job and people working. At 3 PM I came to the Unit. Girls were in the office (med room). I talked to them and they were getting ready to leave. Jill was doing (med) count and I went into activities. Played games, talking, singing, being happy. Then it was time for dinner. I pushed people in, set up tables. I was like, where's [REDACTED]. Jill said, 'She must be out.' She said, 'I don't know why she's out and they (day shift) didn't give her meds.' Usually family doesn't take her out, they usually visit. I didn't think anything about it. I got through cleaning the kitchen, took people to activities, took Millie to the other building, took garbage out. Jill says it seems kind of strange that [REDACTED] out and no one's called. I had no idea that she was in the bathroom. I find it strange that she was in there. I didn't look at the 24 hour report, usually the med passer does. I'm in activity. Jill first started asking about Loretta around 4:45 -5 PM. We didn't make calls to supervisors. I thought it was strange that [REDACTED] wasn't here. She never misses a meal, even when she's sick she still eats slowly. When her daughter's come and take her to a doctor visit she's usually back.

Jill said, 'I hope they're fixing a plate.' She said, 'They could have told us.' I said, 'It's strange she's not here.' I started opening doors. Instead of looking, Jill called the family. There was lots of commotion. I asked when the last time she was toileted.

(After the EMTs arrive) Jill was talking to the police. She said so and so left her on the toilet. Sue (Director of Wellness) was on my phone. I gave the phone to Jill. (Someone) said to Jill, 'You're talking too much. What you should have done first is look before you call the family.' We should have laid eyes on everyone.

*J. Barth*  
10/4/17

Statement by Kim Mims

Taken by Debra Barth, Executive Director

Re: Incident with REDACTED on 10/4/17

REDACTED was the last person to eat lunch. She was wet around 2 PM. I took her to the bathroom for about 10 minutes. I took her back to the toilet around 2:50 or 2:55 PM. I had a conversation with James regarding resident B\*\*. I told Jill that REDACTED was on the toilet and she needed to get her off. Jill was talking to resident S\*\* and his caregiver. Jill was getting up to go to the med room. Jill gave me a nod. I thought she heard me. It was quiet. James would have heard me, too.

*Debra Barth*  
10/5/17



5:40 PM Oct. 5, 2017

Officer Dibb from the Greendale Police Dept came to HV and met with Shawn Lynch and myself.

He recalled the phone conversation that was overheard between caregiver Jill and DOW Sue Marek.

He saw James hand Jill the phone. The phone was on speaker phone. Sue said to Jill, "You need to shut your mouth. Quit talking." Jill then walked away from the area with the phone and continued talking to Sue.

The Son in law, a para medic and Officer Dibbs heard part of the conversation as the phone was on speaker. They were uncomfortable with how the interaction between Sue and Jill sounded. The officer said when someone tells another person to shut up it can be because they don't want them to give information.

He said the Paramedic commented to him when leaving the community about the comment.

Officer Dibb said that in retrospect he thought that given the dynamics of the situation and the fact that Jill was excitable and talking over the fire fighters and officer, Sue may have been attempting to quiet her.

Officer Dibb said he was called by the firefighter because someone was being unruly. He initially thought it was a patient, but when he got to the scene he realized it wasn't. He thought the call may have been because of the caregiver. He said he also may have been called to determine if there was criminal intent.

We discussed my investigation so far and he does not believe there was criminal intent.

J. Dabbs GD  
10/5/17